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1987 MEDICARE BUDGET ISSUES

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HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

MARCH 6, 1986

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1987 MEDICARE BUDGET ISSUES

THURSDAY, MARCH 6, 1986

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 1100, Longworth House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, FEBRUARY 21, 1986

PR #7
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D. C. 20515
TELEPHONE: (202) 225-3627

THE HONORABLE FORTNEY H. (PETE) STARK (D. CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON 1987 MEDICARE BUDGET ISSUES TO BE HELD ON THURSDAY, MARCH 6, 1986

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, today announced a hearing on the medicare provisions of the Administration's proposed fiscal year 1987 budget. It will be held on Thursday, March 6, 1986, at 9:30 a.m., in the Committee's main hearing room, 1100 Longworth House Office Building.

The hearing will focus on both the legislative and regulatory medicare proposals in the Administration's fiscal year 1987 budget. Major proposals provide for medical education payment reforms, physician payment reforms and beneficiary expense increases. The President's budget also provides a regulatory initiative for the inclusion of capital in the prospective payment system. However, the testimony relating to payment for captial costs will be heard at a separate hearing on Monday, February 24, 1986 (See PR #5).

Witnesses will be asked to comment on the impact that the Administration's budget proposals will have on medicare beneficiaries and providers.

BACKGROUND

Over the past five years, large budget reductions and major policy changes have been enacted in the medicare program. Recently enacted changes are estimated to reduce medicare costs by approximately $45 billion during the period 1984-1988. This reduction in medicare costs is due to numerous policy changes that have cut payments to providers and increased out-of-pocket costs to medicare beneficiaries. These changes include major innovations like the prospective payment system for hospitals, enacted in 1983, that completely altered the payment procedures that had been in effect for decades.

The Subcommittee must evaluate the merits of each of the medicare proposals contained in the President's budget. We must also consider these proposed changes in light of the current disruption and problems in the medicare program caused by the many policy changes and budget cuts that have been implemented in the past several years.

According to the Administration, the President's fiscal year 1987 budget is estimated to reduce projected medicare expenditures by nearly $4 billion in fiscal year 1987, as well as increase by $725 million the part B premiums paid by beneficiaries. Highlights of the President's budget include:

- Limiting the increase in medicare hospital payments;
- Eliminating direct medical education payments for education expenses and allied health training coupled with the establishment of hospital-specific limits;
- Reducing payments for indirect medical education by one-half;
- Imposing selective physician payment reforms;
- Increasing the part B premium to 35% of program costs for individuals and to 50% for third-party payors who buy part B coverage;
- Delaying eligibility to the start of the first month following the 65th birthday;
- Expanding medicare secondary payor for the working aged over 69 and disabled spouses and dependents; and
- Instituting a copayment for home health services and services provided in ambulatory surgical centers.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests by calling Harriett Lawler [(202) 225-3627] no later than close of business Friday, February 28, 1986, to be followed by a formal written request to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee staff (202) 225-7785.

In view of the limited time available to hear witnesses, the Subcommittee may not be able to accommodate all requests to be heard. Those persons and organizations not scheduled for an oral appearance will be encouraged to submit written statements for the record of the hearing. All persons requesting to be heard, whether they are scheduled for oral testimony or not, will be notified as soon as possible after the filing deadline.

It is urged that persons and organizations having a common position make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. This process will afford more time for members to question witnesses. In addition, witnesses may be grouped into panels with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question witnesses, witnesses invited to appear before the Subcommittee are asked to comply with the following requirements:

1. Witnesses should submit 100 copies of their written statement to the Health Subcommittee, 1114 Longworth House Office Building, no later than noon Wednesday, February 26, 1986.

2. Each statement to be presented to the Subcommittee or any written statement submitted for the record should contain the following:

   a. The name, full address, and capacity in which the witness will appear (as well as a telephone number where the witness or a designated representative may be reached);

   b. A list of any clients or persons, or any organization for whom the witness appears; and

   c. A topical outline or summary of comments and recommendations.

3. Witnesses should not read their written statements to the Subcommittee, but should instead limit their oral presentations to a summary of the points included in the statement. Witnesses are requested to limit their oral summaries to no more than five minutes.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six copies are required and must be submitted by close of business on Friday, March 28, 1986, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. (See other requirements under #2 above.) An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

****

Chairman STARK. The Subcommittee on Health will proceed and we are meeting today to begin the discussion or debate about the Medicare budget the administration has proposed for next year, fiscal year 1987.

We all feel pressure to reduce the deficit and the administration has come up with a plan that would reduce anticipated spending on entitlement programs by $115 billion over the next 5 years. Almost half of that involves cuts in the Medicare Program; $53 billion, I believe, and change.

That is a lot of money and as we have known on this committee for a long time, trimming the budget is neither easy nor fun but there are recommendations here that are quite disturbing.

Half of these Medicare cuts result in the charges on beneficiaries being increased. And there is a suggestion, from an administration that opposes tax increases, that we simply raise Medicare premiums by more than $18 billion. That is a lot of money to ask from people who do not have much to begin with. It would more than double the part B premium by the end of this decade.

The beneficiaries who are now paying a bit more than $15 a month for coverage would see their premiums double, to more than $30 within a few years. When you realize that the average beneficiary is trying to live on a bit more than $10,000 a year and millions are getting by on a lot less than that—about 2 million of them are living way below the poverty line—you can understand why that would not be an easy increase for them to swallow.

But that is not the most offensive part of the package. The other recommended beneficiary cuts are worse. They ask that the sick pay more for the services they need. Every year the administration asks us to make the sick pay more for their care and every year we refuse, but the message does not seem to come through.

Given their enthusiasm for such cuts, I am fearful I will find a rock on my living room floor, tossed through the window, saying stop me before I slash again.

But you may be sure that this subcommittee will do its best to hold back those cuts.

We are going to hear recommendations for changes in the way the Government pays physicians and that would obviously result in the patients paying even more, physicians being as generous as they are.

In some areas, the recommendations seem more sensible. There is a continuing drive to require providers to be more efficient and we will be looking at those to see what results they will produce. It is our hope that today's hearing will provide an informed picture of the impact these changes would have on the Medicare budget, on providers, but most importantly on the millions of Medicare beneficiaries who depend on their program for needed medical care.

And I would like to call the witnesses' and the observers' attention, and the committee's attention to somewhat of a departure from the outline of our witness list. This is not directed at the administration but at an interesting phenomena that happens in this committee.

As we began to look at the people who requested to testify, I think literally we had an inverse proportion. Of the $53 billion in cuts, a mere $2 billion comes from what I would refer to as other providers. We had 50 requests to testify on that $2 billion of cuts, mostly from our friends and advocates here in town. And only two or three requests to testify on behalf of the 30 million beneficiaries who are going to swallow $25 billion in cuts.

And I thought it important to point out how these cuts are focused and I hope that my colleagues on the committee, and the others, will forgive me the poetic license in outlining this hearing as we have today, but I think it is important that we understand how these cuts are directed.

Dr. Desmarais, who is the Acting Administrator of the Health Care Financing Administration of the Department of Health and Human Services is here to make an eloquent case for the administration's proposal. And we recognize, Doctor, the difficulty in cutting budgets. We are concerned with the budgets of several agencies and yours is no easy task. And I hope that together we can find the best way to deal with this problem of saving money and protecting the interests of beneficiaries.

I have been informed that there are no other opening statements and so, without objection, I would ask you to proceed. We have your complete statement. Without objection, it will appear in the record in its entirety.

I have been informed that you may be willing to stay with us until about 1:30 in case there are other questions raised by subsequent witnesses. It would certainly be of help to us to have you or your staff's input into these areas that will be discussed by witnesses who follow you.

Proceed.

STATEMENT OF HENRY R. DESMARAIS, M.D., ACTING ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY THOMAS AULT, ACTING DEPUTY DIRECTOR, OFFICE OF LEGISLATION AND POLICY; CHRIS GAMBLE, DIRECTOR, DIVISION OF BUDGET; AND CHARLES BOOTH, DIRECTOR, OFFICE OF REIMBURSEMENT POLICY

Dr. **Desmarais**. Thank you, Mr. Chairman.

My name is Henry Desmarais and I am here to talk about the administration's fiscal year 1987 budget proposals in the area of Medicare. I will take only some time to summarize some of the highlights of those proposals and, as you have noted, will enter my full statement in the record.

The proposals for fiscal year 1987 are estimated to save $4 billion in the Medicare Program and also provide an additional income to the Medicare trust funds of approximately $700 million. I note that many people speak about budget cuts with respect to these proposals, including—I noted—your own witness list, in describing the different panels, noted that there were panels reflecting different categories of cuts.

I think it is instructive to know that what we are talking about actually is decreasing the rate of growth as a result of these proposals. Without the proposals in the budget, we are looking at Medicare increases for fiscal year 1987 of approximately 9 percent.

With adoption of every single one of the proposals in the President's budget, we will reduce that to 4 percent.

So in a sense, there are cuts. There are savings. But there is, more correctly, a decrease in the rate of growth. And what we are all about here is trying to stretch the Medicare dollar as far as it will go and to do this in the most efficient manner possible, because we all know we do have a Medicare insolvency problem. The last trustee's report estimated that the Hospital Insurance Trust Fund would be insolvent by 1998 and the actuaries projected, at the time, that for the next 25 years the shortfall would be $1 trillion. That is certainly not an inconsequential amount.

We also observe that, in coming to the decisions that we did for this budget, we were mindful of the Gramm-Rudman-Hollings budget targets for fiscal year 1987.

Let me summarize some of the key parts of the budget proposal, and then be prepared to take your questions on those and any other subjects.

The first one you have already heard about, and that is the area of capital, where we are proposing to remove the bias currently in place in favor of capital for purposes of hospital reimbursement, and instead pay for that item as we do the operating costs for hospitals, under the prospective payment system.

You have already heard from Dr. Robert Helms, the Acting Assistant Secretary for Planning and Evaluation, and I only pause here to add our own word of support for this kind of initiative because we believe it will add additional incentives already inherent in the system.

Medical education is certainly part of many of the proposals submitted in the budget. Once again, we are recommending that the indirect medical education adjustment, which is part and parcel of the prospective payment system, be undoubled to more carefully reflect what is supported by empiric evidence.

The Congress had chosen to double the adjustment over and above what was supported by regression analyses. We are heartened by the fact that during the reconciliation deliberations, the Congress has seen to reduce or to recommend reduction in that percentage add-on.

Similarly, we are proposing, through regulation, to modify the adjustment. Today it is a straight line increase. The larger your intern and resident program, the more the adjustment. Instead, we would replace that with a curvilinear relationship.

And this, too, has been something supported and discussed during the reconciliation process.

And finally, in medical education, we are proposing, through rulemaking, to modify the direct medical education payments. These are for stipends of interns and residents. We are proposing to pay only for the services of interns and residents, as reflected in their stipends and their fringe benefits, and to stop paying for the education subsidies, including those that are earmarked for nursing education programs run by hospitals as well as allied health programs that are run by hospitals.

The second cluster, another cluster of proposals, relate to physician reimbursement. And I think, here, again it is good to talk about cuts versus what we really are talking about. Despite the fee freeze that has been in place since July 1984, the actuaries tell me that the Medicare payments for physician services are nevertheless increasing at about 12 percent per year.

And again here, if we were to propose nothing in this area, we would expect a further 12-percent increase during fiscal year 1987.

I have already, in testimony before the Senate, made very clear the administration's support in moving towards capitation as a way of paying for physician's services. And of course, we have already begun that process through Congress having the TEFRA proposal dealing with health maintenance organizations and competitive medical plans.

Already, about 500,000 Medicare beneficiaries are getting their health care services through these risk entities. By 1990, we project about 25 percent of Medicare beneficiaries might be so served.

In the meantime, though, while we move toward capitation, we are—in this budget—proposing to make a variety of refinements in the current reasonable charge system. Many of these refinements have been suggested either by the General Accounting Office and the Inspector General. They have been the subject of Congressional hearings and, in fact, some of them have been discussed through the reconciliation process.

In total, they would save about $432 million in fiscal year 1987.

I will briefly mention the five elements in our proposal. One would be to identify overpriced procedures and to invoke inherent reasonableness to lower the reasonable charges for those types of services. Currently, our contractors—the Medicare contractors—do have authority to do that in their own locales if they have evidence which suggests that the reasonable charges would be too high otherwise.

And recently, we have published regulations that would give the Secretary the same authority at the national level.

I might pause and use an analogy; the analogy here would be the computer analogy. If we had set what we were paying for computers 10 years ago as the base price and continued to add to that base price each year thereafter, we would certainly be paying a lot more for computers today than we, in fact, are. Because what has occurred is increased technology, and so the price of computers has fallen.

We do not observe that kind of a relationship on physician services. People speak about the stickiness of the reasonable charge system.

A second item would be to adjust the reimbursement for standby anesthesia. This is something that about seven of the Medicare contractors are already doing, under their own authority. It is something that has been recommended by the Inspector General and something we plan to do through the rulemaking process.

Third, we propose to reduce postcataract surgery payments for both contact lenses that are given as part of that treatment, as well as related professional services. This has been the subject of hearings before the House Aging Committee, and has also been the subject of recommendations by the General Accounting Office.

Fourth, we are proposing to limit the instances wherein we pay for assistants at surgery. This is based, in part, on some research that shows the use of assistants at surgery varies dramatically across the country. In some States, an assistant for a particular surgical procedure may always be used. In another State, almost never. And yet, the outcomes, from a quality perspective, do not seem to be any different.

This item has been the subject of discussions during reconciliation and has also been the subject of an Inspector General report.

And finally, we are proposing to correct an overstatement in the Medicare Economic Index. In that index, there is a proxy that is meant to reflect the cost of physician office space. And the proxy has used the mortgage cost, rather than a rental cost. So we are proposing to substitute the mortgage proxy for a rental proxy, which we believe is more appropriate. And in fact, for the Consumer Price Index, the Bureau of Labor Statistics has already made that correction.

I briefly mentioned our support for capitation and I would like to pause here to speak about another element of our budget proposal and that is the proposal for a voluntary voucher system. Some view this as a dramatic departure from the way Medicare has operated up until now. But in reality, I think it simply builds upon our HMO and Competitive Medical Plan authorities and simply adds entities that would qualify to get the kind of capitated payment which HMO's receive today. For example, indemnity insurers would be added.

And in this process, if a beneficiary so chose to proceed with a voucher, they would receive an actuarily equivalent benefit package.

To give you an example of what this would allow, it would allow a very large company—a General Motors or some other large company who already provides the health benefit plan for their employees—to continue to do so at the time the employee reaches retirement age and becomes an annuitant of the company.

Today, that is not permitted. And so a voucher would allow a Medicare contribution to be commingled with an employer contribution and perhaps even a beneficiary contribution to provide a single health benefits package. And in fact, would simply be continuing what the beneficiary has already been experiencing while he worked for the company.

Several of the proposals in the budget do have a beneficiary cost sharing implication and I would like to talk about just one of those.

This is the one we proposed on the part B premium under Medicare. Many people pride themselves on the fact that Medicare is an insurance program. It is a somewhat curious one, however, in that the premium that is paid by the policy holders only covers about 25 percent of the costs of the policy or the costs of the benefits provided under part B of Medicare.

All of you are aware of the fact that at the beginning of the program, the premium covered 50 percent of the costs of the benefits provided under the program. And over time, that has fallen to 25 percent.

In this budget, we propose that over a 5-year period, the premium would gradually cover 35 percent of the costs of the benefit package. Were this to be adopted, and if all of our other part B proposals were also adopted, the premium increase on a monthly basis would be about 90 cents for each one of our beneficiaries, under this proposal, in calendar year 1987.

There are a number of other proposals. I think I would just like to mention one additional proposal that has also been the subject of some discussion in reconciliation. That is the Medicare secondary payer provision.

We already make Medicare the secondary payer in instances where beneficiaries from the ages of 65 to 69 have available to them an employer health plan. We propose to expand the age beyond the age of 69. There has been agreement on this during the reconciliation process. Furthermore, we are proposing to make Medicare secondary when any one of our disabled beneficiaries also has private insurance available to them, perhaps because their spouse is working. This has been a recommendation of the General Accounting Office.

There are many other proposals I could mention but I think time will not permit me. I would like to end by making mention of the fact that in putting this budget together and in working to operate the Medicare Program, we are trying to focus a great deal of attention on the quality of care aspects. We are doing this in a number of ways. One of them is by continuing to refine the way our peer review organizations do their work. Our revised scope of work that will apply for the next 2-year contractual period is much more focused on quality of care than the first 2-year contract.

We are working to educate beneficiaries. Quite recently we provided a standard message that will be given to each beneficiary at the time of admission to the hospital, describing to that beneficiary what their appeal rights are, how important it is to discuss their situation with their physician and how the prospective payment system is not meant to discharge them prematurely.

Finally, we are doing a number of quality of care studies. We intend to continue to do those, to monitor exactly what is going on out there and to be careful that quality of care is not compromised.

Mr. Chairman, this concludes my opening statement. I am available for questions.

[The prepared statement follows:]

STATEMENT OF HENRY DESMARAIS, M.D., ACTING ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

I am pleased to be with you today to discuss our Medicare proposals for FY 1987. Our 1987 budget reflects the Administration's strong commitment to containing health care costs while maintaining quality of care. We see our budgetary measures as essential to preserve the economic gains we have made in the past few years and to assure the continued availability of quality health care for the elderly and disabled who rely on Medicare to meet their basic health care needs.

When this Administration took office, Medicare costs were rising at 21 percent a year. In the current fiscal year, that growth has declined to about 5 percent. This has been accomplished through specific health care reforms designed to restore a competitive environment in the health marketplace. The decline in the growth of program costs has been accomplished with assurances that access to quality health care for our beneficiaries is maintained. In 1987, we must exert continued efforts to constrain health care costs which, despite our efforts continue to grow at twice the rate of overall inflation.

BACKGROUND ON MEDICARE

As you know, the Medicare program has enacted in 1965 to provide insurance coverage of hospital, physican and other medical services for our nation's aged, and was extended in 1973 to disabled individuals. In 1987, the program will cover approximately 29 million aged and 3 million disabled individuals. Under our Medicare proposals for 1987, total Medicare outlays—including the impact of our legislative and regulatory proposals—are estimated to be $77.5 billion, 4 percent higher than the current 1986 estimate. Without our new initiatives, outlays would increase by 9 percent.

In general, the 1987 budget proposes to refine the prospective payment system (PPS) by incorporating hospital capital reimbursement into the payment rates, to revise graduate medical education payments, and to restrain increases in physician and other provider spending while continuing to encourage competition in the health care sector. In total, these proposals would reduce Medicare expenditures by $4.0 billion in 1987 and by $37.3 billion over the next five years. Further, general fund subsidies to the Medicare trust funds would be reduced by $0.7 billion in 1987 and by $17.2 billion through 1991 by restoring the percentage of the Part B premium paid by individuals closer to the initially intended levels.

In developing our 1987 budget proposals, we are again proposing that the majority of savings come from providers. Only modest savings would come from beneficiary cost-sharing provisions. Let me briefly describe our major Medicare proposals designed to further slow growth in the costs of health care.

INCORPORATE PAYMENT FOR HOSPITAL CAPITAL COSTS INTO THE MEDICARE PPS

Dr. Robert Helms, Acting Assistant Secretary for Planning and Evaluation, appeared before this Subcommittee on February 24th to discuss our proposal to incorporate payment for hospital capital costs into the Medicare prospective payment system. We believe this is the next logical step in our efforts to reform the Medicare reimbursement system. This change would end the current reimbursement bias in favor of capital and would enhance the incentives to cost-effectiveness inherent in Medicare's prospective payment system. Our capital provisions would save $456 million in 1987.

PHYSICIAN REIMBURSEMENT REFORM

Although the rate of increase of physician payment spending has slowed, the increase is still larger than the increase for any other function in the Federal budget except international affairs. Without the changes proposed in the budget, Medicare FY 1987 physician payments are projected to increase by $2.1 billion or 12 percent above 1986 levels.

Our proposals make physician payment reforms that can all be addressed under current authority. These proposals will result in savings of $432 million in FY 1987.

First, our proposal would:

Reduce payments for overpriced procedures

Payment for physicians' services is determined on the basis of customary, prevailing and reasonable (CPR) charges. Under this system, charges for new procedures are initially priced high because of the new technologies involved. After a procedure becomes commonplace, these initial payment levels are artifically maintained under the CPR system despite technological or productivity advances. For example, improved medical technology resulting in lower costs, or reduction in the time required to perform certain procedures due to increased medical proficiency, should result in lower charges, but this does not appear to happen.

Carriers currently have the authority to use factors other than "customary, prevailing and reasonable" (CPR) in judging whether a charge for a specific service is inherently reasonable. We are currently developing inherent reasonableness regulations that would set forth the process for establishing reimbursement methods for individual procedures when the standard CPR reimbursement methodology results in payments that are not inherently reasonable. We would publish notices about individual medical procedures in the *Federal Register* and provide an opportunity for public comment.

Our physician reimbursement reform proposal will also:

Limit post-cataract surgery payments

Following recommendations by the General Accounting Office and in response to Congressional concern, we would require carriers to use inherent reasonableness authority to set separate and more appropriate reasonableness charges for prosthetic lens and related professional services. We have adopted stricter criteria to ensure the medical necessity of lens replacements.

Limit payments for assistants at surgery

Under a recently implemented initiative, we are providing payment for assistants at cataract surgery only when supported by specific justification as to medical necessity. Our FY 1987 proposals would extend this provision to other surgical procedures.

Reduce payments for standby anesthesia

Currently, Medicare pays a physician an equal amount for administering general anesthesia or for "standing by" and monitoring the general care of a patient during a surgical procedure when the surgeon administers local anesthesia. Consistent with the recommendations of the Department's Inspector General, we would limit payments to "stand-by" anesthesiologists.

Correct an overstatement of the Medicare Economic Index (MEI)

The physician reform proposal would adjust the Medicare physician economic index, which limits increases in prevailing charges, to correct for the historical overstatement of housing costs. Correcting this technical flaw would be a one time adjustment in FY 1987.

LIMIT ON REIMBURSEMENT FOR GRADUATE MEDICAL EDUCATION

We will also undertake several payment reforms in the graduate medical education area as part of our broader effort to take account of dramatic gains, even to the point of surplus, in the supply of health professionals.

Medicare currently reimburses hospitals for its share of the direct costs of medical education. These costs include salaries and education expenses for residents, allied health professionals and nurses. In FY 1985, Medicare payments for these purposes totaled about $1.2 billion dollars.

As required by law, we will continue to make payments for the salaries of residents and interns as payment for the services they provide to Medicare beneficiaries. However, through rulemaking, we plan to eliminate Medicare payments for education subsidies, including those for nursing education and allied health programs.

INDIRECT MEDICAL EDUCATION

Medicare also reimburses teaching hospitals an additional amount for the indirect costs associated with teaching programs. As required in the original prospective payment legislation, current payment for indirect medical education is twice that justified by empirical evidence. We are therefore proposing a legislative amendment to eliminate the doubling of this payment.

The medical education proposals in the FY 1987 budget will save $1.3 billion in 1987 and $8.9 billion between 1987 and 1991.

MAINTAIN CLINICAL LABORATORY FEES

Consistent with our overall policy of limiting the unnecessary growth in health care costs, we propose, through legislation, to maintain at existing levels reimbursement for laboratory services performed in clinical laboratories, physician's offices and in hospital outpatient departments for one year.

In addition, to preclude excessive spending for hospital laboratory services, we will undertake rulemaking to establish reasonable cost limits for tests performed in hospital outpatient departments when the current fee schedule expires in July 1987.

These proposals would generate an expected savings of $55 million in 1987 and $0.2 billion over the next five years.

MODIFY PAYMENTS FOR NON-PHYSICIAN ITEMS AND SERVICES

Evidence indicates that Medicare is paying excessive amounts for some non-physician items and services—primarily durable medical equipment. To ensure that Medicare does not overpay for these services, reasonable charge levels will be reviewed and payments will be revised, where appropriate, to reduce overpriced items and services. This proposal will save $70 million in 1987 and $0.5 billion from 1987 to 1991.

REVISE END-STAGE RENAL DIALYSIS RATES

We will also revise, through the regulatory process, the End-Stage Renal Disease (ESRD) dialysis rates. Medicare currently makes separate facility and physician payment under the ESRD program for routine dialysis performed on an outpatient basis. Since 1983, payment rates for outpatient dialysis have been established on a prospective basis. For routine dialysis, the supervising physician receives a monthly capitation rate and the facility receives a per treatment fee. Under this proposal, the facility fee would be updated using the most recent data available while the monthly physician capitation payment would be revised to correct a methodological error. Facility rates will fall as a result of more appropriate weighting of treatment and facility mix in rate computations. Recent information from a General Accounting Office study shows that in-home treatment requires only 25 percent of the physician time and effort as facility dialysis, instead of the originally assumed 70 percent. This data will be used to revise the monthly capitated rates paid to physicians. Updating the facility and physician rates will result in savings of $90 million in 1987 and $0.6 billion over the next five years.

END STAGE RENAL DISEASE NETWORK COORDINATING COUNCILS

Our FY 1987 budget proposals would also eliminate, through legislation, the requirement for ESRD Network Coordinating Councils. We believe these networks are inefficient and ineffective in ensuring quality and appropriateness of care. This proposal would eliminate the newworks entirely by FY 1987 and would save $1 mission in 1987.

FIRST FULL MONTH OF ELIGIBILTY

We are also proposing legislation to begin Medicare eligibility on the first day of the month after an individual reaches age 65. This proposal would result in significant program savings, $265 million in 1987, without imposing a hardship on beneficiaries since the large majority of individuals have private insurance which generally extends until the beginning of Medicare coverage.

This proposal is expected to save $265 million in 1987 and $1.6 billion through 1991.

EXTEND MEDICARE AS SECONDARY PAYER FOR WORKING AGED OVER 69 AND DISABLED SPOUSES AND DEPENDENTS

This proposal would extend Medicare as the secondary payer for beneficiaries over age 69 if they or their spouse work and elect employer-based insurance. Further, as recommended by GAO, the secondary payer provision would be extended to disabled beneficiaries who are also convered under an employer health plan. This proposal would save the trust fund $540 million in 1987 and $3.2 billion from 1987 to 1991 while having little or no affect on beneficiary liability.

OTHER MEDICARE PROPOSALS

Our 1987 budget also proposes to save $414 million in 1987 by: Revising the process for determining whether payments to providers should be made for noncovered services; changing return on equity capital payments made to facilities other than inpatient hospitals; imposing the standard Part B coinsurance and deductible for surgery done in ambulatory surgical centers; and by simplifying processing of Medicare Part A bills.

BENEFICIARY COST-SHARING PROPOSALS

We are also proposing several beneficiary cost-sharing provisions. Under the Medicare home health benefit, we propose to:

ESTABLISH A COPAYMENT FOR HOME HEALTH SERVICES

Home health services are currently the only major Medicare service not subject to any beneficiary cost-sharing. In addition, other limits on utilization were eliminated in 1980. Evidence that home health services may be inappropriately utilized is evident in studies performed by the General Accounting Office (GAO) in 1979 and 1981 and by a HCFA study in 1985 all of which indicate that approximately one-third of all home health services should have been denied as being medically unnecessary or not covered under the Medicare program.

This proposal would establish, through legislation, a small copayment for those beneficiaries whose need for services is unrelated to a hospital or skilled nursing facility stay and, therefore, have not been subject to the hospital deductible. We have also built into this proposal a safeguard for those patients whose care needs continue beyond the 100th visit by requiring the copayment only for the first 100 visits. We believe that copayments and deductibles serve as a positive incentive for physicians and beneficiaries to carefully consider the necessity for health care services.

To further assure the appropriateness and medical necessity of home health services, we will begin a management initiative to look at the problem of inappropriate utilization, focusing on physicians who show patterns of ordering unnecessary visits or of not closely monitoring patients' needs.

These proposals will result in savings of $100 million in 1987 and $0.6 billion over the next five years.

GRADUAL CHANGE IN THE MEDICARE PART B PREMIUM

Currently, Medicare beneficiary premiums for Part B cover about 25 percent of program costs. Beginning with calendar year 1987, we propose a gradual increase in this premium. We would increase the premium two percentage points per year over the next five years, so that by calendar year 1991 the premium would be set at a rate equal to 35 percent of estimated costs. In 1987, this would amount to an increase of $.90 a month. I might add that the premium was originally designed to cover 50 percent of program costs.

For third party payers who buy Medicare Part B coverage, the premiums would be set at 50 percent of costs as required by the original legislation. This primarily affects the States which pay the Medicare premium for their Medicaid recipients. Federal Financing participation (FFP) would, however, still be available to States that "buy-in" to Medicaid recipients.

These changes in the Part B premium would be accomplished through legislation and would increase Medicare premium income by $725 million in 1987 and by $17.2 billion through 1991.

INCREASE IN PART B DEDUCTIBLE

We also propose to amend current law to raise the Part B deductible from $75 to $100 in 1987 and then index it to the Medicare Economic Index beginning in 1988. This provision would help maintain the real dollar value of the deductible, which has increased only twice since Medicare was established: from $50 to $60 in 1973 and to $75 in 1982. I might add, that if the original $50 deductible had increased by the rate of inflation as measured by the Consumer Price index, the 1987 deductible would be $180. This proposal would save $300 in 1987 and $3.0 billion through 1991.

VOUCHER PROPOSAL

The final Medicare proposal I will discuss today is the Medicare voucher proposal. We believe that increased competition and consumer choice are the key to controlling spending and ensuring quality services. We are working to expand competition: by encouraging the growth of health maintenance organizations (HMOs) and competitive medical plans (CMPs); by increasing capitation options with vouchers; and by examining new approaches to capitation.

Almost half a million beneficiaries are currently enrolled in 113 risk-sharing HMOs and CMPs and some outside experts estimate that 25 percent of all Medicaid beneficiaries will be served by HMOs and CMPs by 1990. Our 1987 Medicare voucher proposal would further expand opportunities for Medicare beneficiaries to use their health benefits to enroll in a wider array of private health plans as an alternative to traditional Medicare coverage.

The voluntary voucher program builds on the HMO/CMP provisions enacted in the Tax Equity and Fiscal Responsibility Act of 1982. This legislative initiative would further systemwide health care reform by: broadening the definition of qualified organizations; giving insurers and employers the flexibility to combine the Medicare payment and premiums for Medigap policies to create single, integrated, efficient health plans, and by providing Medicare beneficiaries additional options in their selection of private health care plans.

Beginning in 1987, plans would receive payments at 95 percent of the average adjusted Medicare per-capita cost and, in exchange, would be required to provide a benefit package that is at least equivalent in value to that provided by Medicare. This program would be entirely voluntary, and beneficiaries would be able to reenter the traditional Medicare system if they chose to do so.

CONCLUSION

In conclusion, we believe our 1987 Medicare proposals are absolutely necessary to bring the growth in health care costs more in line with the growth in other areas of the economy. Our Medicare proposals build on our success in reversing the escalation in health care costs which has jeopardized the solvency of the Medicare Trust Fund. Our proposals represent responsible program reform and, along with other areas of the President's budget, contribute significantly to reducing the Federal deficit. I will be pleased to answer any questions you may have.

Chairman **Stark**. Thank you very much.

Mr. Gradison.

Mr. **Gradison**. I have no questions. Thank you.

Chairman **Stark**. Mr Coyne.

[No response.]

Chairman **Stark**. Mr. Daub.

Mr. **Daub**. Mr. Chairman, I appreciate the summarized and specific testimony. You undertake to represent to this committee a massive amount of change over time.

If you had to put them in priority, what do you want to do first?

Dr. **Desmarais**. I don't think we have the luxury of doing some things first. I think we certainly have a budget target to meet. I think all of the proposals are doable. It certainly would be a workload for us and an adjustment for Medicare beneficiaries and for providers of care and so on. It is certainly a monumental task. We feel we do need to make progress. I would be reluctant to try to prioritize them.

I think there are different kinds of proposals in there, some aimed at inducing efficiency among providers, some aimed at the cost sharing side—there is a lot of research showing that cost sharing does lead to less over utilization, for example, in the home health area. We do have a proposal on a copayment in there. I think there are a variety of approaches we are trying to outline here.

Mr. **Daub**. Does the administration have a position on means testing Medicare?

Dr. **Desmarais**. Means testing is not something that is clearly a part of this budget, although we are aware of the interest in that. It is not something the administration has come out in support of.

Mr. **Daub**. Thank you, Mr. Chairman.

Chairman **Stark**. Doctor, Is it a correct summarization that out of your 5-year cuts, about half will increase the cost to beneficiaries?

Dr. **Desmarais**. I don't believe so, Mr. Chairman. I don't know if the half is meant to reflect every time there is a change on the physician's side, an automatic assumption that the beneficiaries' costs will increase——

Chairman **Stark**. I didn't even include that. I just included those items that you have talked about in terms of copays and premiums. That gets us to $23 billion. That is close enough to half, I would suspect, 47 percent. That does not include any of the hospital reimbursement cuts or any of the physician reimbursement cuts. That is just the increase in premiums.

Is that a fair ballpark estimate, about $23 billion out of the $53 billion over the 5 years will result in increased costs to beneficiaries?

Dr. DESMARAIS. I am not exactly sure. I know that for fiscal year 1987, a preliminary staff-look had said about 15 percent of the savings were to come from the beneficiary side.

Chairman STARK. CBO says almost half of the Federal savings would come from proposals to increase the cost paid by beneficiaries or their insurance companies.

Dr. DESMARAIS. Or their insurance companies. I suppose that may reflect some of the premium increases.

Chairman STARK. In this case, we happen to be their insurance company for the Medicare beneficiaries.

Dr. DESMARAIS. Some of the premium increases, of course, are on the Medicaid side. There would be increased costs to the State as well.

Chairman STARK. You don't want to bet me a dollar for every billion I am off, do you?

Dr. DESMARAIS. I would be happy to submit something for the record.

Chairman STARK. Tell me yes or no. Is it about $23 billion of increased costs to the beneficiaries or their insurance companies out of your package of about $53 billion of reductions over 5 years?

Dr. DESMARAIS. I'm sorry. I'm just not sure.

Chairman STARK. You are not sure? Are you sure that you are going to save about $52.6 or $52.8 billion over the 5 years in total?

Dr. DESMARAIS. I believe that is the estimate; yes, sir.

Chairman STARK. Should we go through it one lump at a time? I will get my staff to bring me the numbers. I don't want to pick at you. I would hope that you know enough about what you are suggesting to be able to suggest if it isn't approximately $23 billion that is coming out.

Are you increasing the part B premium to save $18.1 billion over 5 years in your proposal?

Dr. DESMARAIS. The increased income would be about $17 billion from the premium side. Part of that is coming from Medicaid, third party payers and not from the beneficiaries.

Chairman STARK. Are you increasing the part B deductible by $2.5 billion over the 5-year total? These are CBO estimates. You may show yours somewhat differently.

Dr. DESMARAIS. Yes. Sometimes the estimates do vary; that's correct.

Chairman STARK. That is the CBO estimate; is it not?

Dr. DESMARAIS. I assume that is what you are reading from; yes.

Chairman STARK. By delaying eligibility, you anticipate saving about $1.6 billion?

Dr. DESMARAIS. That is over a 5-year period?

Chairman STARK. Yes.

Dr. DESMARAIS. That is approximately right, Mr. Chairman.

Chairman STARK. Your major push to cut-down on home health copayments will save a total of $600 million. Is that approximately right?

Dr. DESMARAIS. Yes, about $640 million over the 5-year period we are discussing.

Chairman STARK. That comes up to $23.1 billion out of a proposed total of $53.1 billion. I suppose it is a little more accurate to say that is about 40 percent which directly increases the cost to the beneficiaries or the insurance they pay or the States that have to pay the Medicaid share of part B. Is that a fair statement?

Dr. **Desmarais**. I believe the math must work out; yes, sir.

Chairman **Stark**. You are anticipating saving about $10 billion in hospital reimbursement through your proposed regulation changes on capital; is that not correct?

Dr. **Desmarais**. Approximately correct, sir.

Chairman **Stark**. When do you anticipate those proposed rules?

Dr. **Desmarais**. We would expect at this time to make them part of the prospective payment regulation which, as you know, will be published about June 2 this year.

Chairman **Stark**. Anything that we do after you issue that on our budget accounting, you would count as an increase because of the way the budget system works? Is that not correct?

Dr. **Desmarais**. I do know we have different accounting conventions. I believe CBO certainly would not make that adjustment until much later. In fact, CBO did not make its adjustments even though we had regulations in place and in effect, they waited until——

Chairman **Stark**. OMB would make it, would they not?

Dr. **Desmarais**. I guess if the regulation were in place and in effect, one would say it certainly was current law.

Chairman **Stark**. You have taken approximately another $10 billion out of indirect medical education and $3 billion out of direct to save a little by the interaction so that you get about $12.2 billion out of medical education.

Dr. **Desmarais**. The early estimate on direct medical education over a 5-year period is about $4 billion.

Chairman **Stark**. Did you listen to the President's State of the Union Message?

Dr. **Desmarais**. Yes.

Chairman **Stark**. Didn't he say that he was not going to raise taxes or cut any benefits that benefit the elderly? Isn't that almost an exact quote?

Dr. **Desmarais**. I'm not sure exactly what his words were.

Chairman **Stark**. It is pretty close, isn't it?

Dr. **Desmarais**. I'm not exactly sure, sir.

Chairman **Stark**. Didn't you listen carefully to the President's State of the Union Message?

Dr. **Desmarais**. Yes, I listened, sir.

Chairman **Stark**. The AMA or somebody later on is going to quote it exactly. I just wondered if you had kept that in mind when you put together these budget cuts, of not increasing the cost to the elderly in their health benefits or increasing their Social Security benefits. Was that foremost in your mind when you put together this package?

Dr. **Desmarais**. The beneficiary cost implications were kept in mind by us and in fact, in some of the proposals, for example, the part B premium, that increase would not occur if in fact the Social Security benefits for the beneficiary did not increase. We did keep those kinds of safeguards in mind as we were trying to design these proposals.

I think it is still fair to say, as I said in my opening remarks, that if this is an insurance program and if the premium only pays

25 percent of the cost of the benefit. I'm not sure one could argue that a proposal of increasing it gradually to 35 percent is on its face unreasonable or unfair.

Chairman STARK. I just want to make sure that we understand. The reasonableness and the fairness, I suppose, is in the eye of the beholder or, in this case, the beneficiary who is paying the premium. I just want to make sure we are all perfectly clear where you are getting these savings and who is going to pay for them, and then we can make that decision later.

Would you agree that the average cost of a hospital vary with the size of the hospital?

Dr. DESMARAIS. I think there is some work that suggests that. One wonders is that reasonable, should in fact it vary by bed size.

Chairman STARK. You recognize there are people who say that is the case but you are not sure it should vary with bed size?

Dr. DESMARAIS. That's correct.

Chairman STARK. Would you agree with the theory that teaching hospitals tend to receive sicker and more difficult and costly cases?

Dr. DESMARAIS. Certainly the research shows that the costs in a teaching hospital are higher and people say there are many reasons for that. Probably one of them is the sickness factor of the patients. The teaching setting many people is somewhat inefficient by its very nature because physicians in training, like I once was, may order more tests than a more experienced physician in the community.

Chairman STARK. Does your intellect tell you whether hospitals in large metropolitan areas have higher average costs than those in smaller cities?

Dr. DESMARAIS. I believe there is also some support for that, sir; yes. In fact, as you know, when the prospective payment system was designed, the actual costs that were occurring in each of the metropolitan areas was brought together to generate the payment rates under the system.

Chairman STARK. Isn't it also correct that when you talk about this empirical evidence that shows that we don't have to increase the assistance to teaching hospitals, but your empirical evidence was computed on a different formula than OMB or the PPS's. You added a couple of zingers in there, as I have been led to believe, that were not in the other formulas. They happen to be the area size and bed numbers.

Was that done to get to your number or was there some philosophic or scientific reason that you added the other two variables that most of the other researchers didn't add?

Dr. DESMARAIS. I'm not familiar with the analysis. I do know that there were a number of factors that were made a part of that work when it was run. I'm not sure that there's anything statistically incorrect with that approach.

Chairman STARK. It's just that the one with the four variables comes up to the 8.7 percent that we suggest, and when you add the others, you get back and show that you're right. And I suspect that's where reasonable researchers differ. You really leave it to us to decide, do you not?

Dr. DESMARAIS. Well, I guess th basic question is, do you want to pay more for an appendectomy done in a 100-bed hospital than you do for the same appendectomy done in a 75-bed hospital or make those kinds of adjustments. I think that's a debatable point. What kinds of differences do you wish to recognize from an efficiency standpoint? And simply knowing that historically the costs have been higher may not lead you to think that you need to recognize those costs forever more.

You might wish to, in fact, put in place a system that provides incentives to get people to reflect on what they're doing, and in fact, as we've observed under prospective payment, reduce their costs.

Chairman Stark. I think that's fine. And in doing so, we would then have to close burn units and trauma units and other kinds of facilities that the large, urban hospitals provide. And so if you want to look at this in a purely empirical regression analysis, solid, scientific, cold, hard fact, yes, you can do away with a lot of services that these larger hospitals provide to communities that need them.

It's always been my contention that the people at OMB who seem to drive these budgets know the cost of everything and the value of nothing.

Dr. Desmarais. Well, it's not the people in the administration who are reporting on the profitability of the hospital industry. I believe the industry itself is showing in at least the early years of prospective payment overall, in the aggregate, increased profitability, whether for proprietary hospitals or for nonproprietary hospitals.

Chairman Stark. Do you know offhand how many teaching hospitals there are roughly in the country?

Dr. Desmarais. I believe it's about 1,000, 1,100, I believe.

Chairman Stark. OK. How many of those would you guess are for-profit hospitals or operated by——

Dr. Desmarais. Well, I believe it's probably—well, see, teaching hospitals, the major teaching hospitals, there are only about three or four that are now owned by proprietary chains, but there are probably more proprietary hospitals that have interns and residents in them than that. I don't have a specific number.

When we think of teaching hospitals, most of us think about the ones affiliated with Harvard and Yale. But in fact, anybody who's got an intern and resident on the staff is a teaching hospital by definition.

Chairman Stark. Would you be receptive to postponing publishing your regulations until, say, August?

Dr. Desmarais. Mr. Chairman, I believe under current law we would be required to publish a proposed regulation by approximately June 1, because a final regulation must be in place under current law by September 1, in order to be taking effect on October 1.

Chairman Stark. That's if you intend to include them in the PPS rates.

Dr. Desmarais. I believe the General Counsel's Office has observed, that in their opinion, we need to be prepared to have a capital reimbursement policy in place by October 1. Of course, that assumes that the Congress has not taken any action between now and then, and I know there have been a number of discussions between yourselves and the Secretary on this subject.

Chairman **Stark**. Would you be willing, if we, in a spirit of cooperation, suggested to you that we would just introduce a simple bit of legislation that would postpone that action until we had a chance to deliberate? Would you work with us then and support that legislation?

We'll make it easy for you. You've got a lot of other things, you've got some reports that are due from a couple years back. You could do those between now and June, and then we could work together to see if we could find a way that seemed to be less onerous—I think we both agree that we should fold capital into the PPS Program. There is some question on transition, and there is some question of the effects on some hospitals that may have entered into capital programs, relying on regulations.

I think it's well known to the administration, I'm no fan of paying capital on historic costs or paying a return on equity. I think that's documented.

So I think there's agreement on what we ought to get in the end. How does it seem to you if we just work together and perhaps see if we can work out a system that the hospitals will perceive as less burdensome to them? Would that sound reasonable to you?

Dr. **Desmarais**. Mr. Chairman, I'm sure we would continue to work with you on the issue of capital. And I believe the Secretary will be meeting with you later in the month to continue his dialog with you on this very subject.

Chairman **Stark**. I am sure that the other witnesses will raise questions on these cuts, and I appreciate your willingness to stay, because you do have a thorough understanding of the intricacies of all of the payments that come under this program. It's obvious, or at least should be, that certainly the Chair does not, and it will be helpful in letting us find out who is just screaming to keep up payments that will continue to allow them to be inefficient and wasteful and profitable, and who makes a good case. And I think your willingness to answer future questions in response to some of the witnesses' testimony is very much appreciated.

I think Mr. Pickle would like to inquire at this point.

Mr. Pickle, did you have a statement or wish to inquire?

Mr. **Pickle**. No. Are you in the questioning section?

Chairman **Stark**. I think if you don't wish to inquire of the good doctor, we will proceed with the next witness.

Mr. **Pickle**. Well, I have a question, if you are open at this point.

Chairman **Stark**. Please.

Mr. **Pickle**. Well, Mr. Desmarais, I notice that you had said on page 6 that the physician reform proposal would adjust the Medicare physician economic index, which limits increases in prevailing charges to correct for the historical overstatement of housing costs.

Now I'm concerned about the question of a physician freeze that's been going on now for 27 months, which I think is inherently unfair. As I understand it, you said that that ought to be lifted, that the freeze, at least for 1987, ought to be lifted, if I understand correctly.

But you propose to make changes in the way that the medical economic index is calculated.

Now the MEI is the rate at which it increases the physician fee or adjusts it. In effect, if you put a cap on the increase of the physician fees, and you do it by just changing the method by which the MEI is calculated, what you're really doing, is just changing everything downwards, you're just really not making any consequential change. You're lifting the freeze, but then you're adjusting the MEI downwards. So the physician charges come out about the same, don't they?

Dr. **Desmarais**. No, sir.

Mr. **Pickle**. Why not?

Dr. **Desmarais**. Well, let me explain. First the freeze that we have in place today is many freezes. It's a freeze on the customary; it's a freeze on prevailings, and a freeze on actual charges of nonparticipating physicians.

This change that you and I are discussing would apply to only one aspect of that, and that's the prevailing charge, and it would limit the increase. It would reduce what we otherwise would have expected the increase in the prevailing charges to be.

So any physician whose customary charge is below the prevailing today, really would not be affected by that particular change. So for physicians below the prevailing—and, of course, the prevailing is at the 75th percentile——

Mr. **Pickle**. Well, I'm just saying, it seems to me, as a practical matter, if you say you're going to lift the freeze, and then you calculate the amount of money that you're going to get by downgrading housing costs or changing the MEI index, you, in effect, wash it off. You give and you take away, and there is no real relief to the physicians in this field.

Dr. **Desmarais**. Well, there will be a definite increase for everyone whose customaries is below the prevailing, and there will be a lesser increase for those at the prevailing because of this change.

You are absolutely correct that this adjustment will reduce the increase in the Medicare Economic Index that we would otherwise be publishing.

Mr. **Pickle**. Well, that sounds appealing. But I would ask you, how many physicians are below the prevailing level?

Dr. **Desmarais**. That's a very difficult question to answer. The prevailing, of course, is set at the 75th percentile, so we would expect a certain number of physicians to be under, but it's very difficult to know exactly how many.

Mr. **Pickle**. Well, I don't want to prolong the hearing, but I'm just simply saying to you, my observation is that you do not really help the physician any, except maybe one small group. Basically, if you lift the freeze—and it ought to be lifted—but if you also downgrade the amount of money they get by adjusting the MEI, you really wash it out, and there's no real help.

So I think, Mr. Chairman, I want to look into this matter further. I thank you.

Chairman **Stark**. Thank you very much, Mr. Pickle.

Is it fair to say that your overall program increases the cost—if you assume that nothing is really going to change much, to some beneficiaries—that seems obvious. How much, you and I may debate, but there will be an increased cost, whether it's moving from 25 to 35 percent, to beneficiaries. There will be a reduction of payments to the providers. Those are two elements that are implicit in your proposal; is that not correct?

Dr. DESMARAIS. There are some increased costs to beneficiaries among those; yes, sir.

Chairman STARK. And there is some reduction in payments to the providers.

Dr. DESMARAIS. Right. And in some cases, the reductions may mean that beneficiaries will make up the difference on unassigned physician claims.

Chairman STARK. The third item, the balancing item in this formula, then, is that third parties pick up the difference; is that the idea—States, insurance companies, fill that gap?

Dr. DESMARAIS. I'm not sure I'd characterize it that way, sir, because it's been my observation that Medicare is not necessarily in the lead on making changes, that there are a lot of changes in the private insurance sector as well, and in the Medicaid programs.

I think the whole health care delivery and financing system has been changing very dramatically over the last several years.

Chairman STARK. I understand that. I just want to see if I can get this into focus.

The providers, the hospitals and the docs and the people making equipment and pills, are one group. They're getting somewhat less under your proposal. You're cutting down a couple——

Dr. DESMARAIS. That's correct. And their costs are also falling. So in that sense, there is that effect because of the incentives in the system to be more efficient.

Chairman STARK. OK. We'll hear testimony on that. But costs aren't any more—that's not because of anything that we're doing.

Dr. DESMARAIS. Well, I believe that certainly the prospective payment system and all the other things that are going on have had a role to play, and the changes——

Chairman STARK. But you are cutting the money they receive. And you are also increasing what the beneficiaries pay. But that obviously doesn't balance out, because the overall reduction is $53 billion.

Is that all being saved through increased productivity; is that what you're telling me?

Dr. DESMARAIS. We expect much of it to be saved in that way.

Chairman STARK. And not by States having to pick up more of the Medicaid costs?

Dr. DESMARAIS. Well, some of these proposals will require States—for example, the part B premium—to pay more of the cost.

Chairman STARK. Let me ask you this.

Dr. DESMARAIS. Yes, sir.

Chairman STARK. Out of the $53 billion in reduced Federal input to the medical system, it can either only come from, let's say, four places. It can come from increasing what the beneficiaries pay out of their own pocket. It can come from paying less to the providers. It can come from increased efficiencies or lack of care or less quality, I suppose, in that area, or it can come from some third-party payers.

Now of the $53 billion, what is your estimate of how much is coming out of increased efficiency and improved procedures, and how much is being picked up elsewhere? How do you account for the $53 billion of savings? How much of that is increased efficiency in the system, and how much of that has got to come out of the third-party payers?

Dr. **Desmarais**. Well, you know, many of our reimbursement reforms, for example, if we reduce our capital reimbursement under Medicare, third party payers like Blue Cross and Blue Shield—and you'll be hearing from them—will not step forward and pick that up. So what we expect will occur is that hospitals will have different incentives to work under and will simply have to live within those incentives.

So I don't believe those third-party payers are going to pick that up. You and I have already discussed dividing the beneficiary and State share versus the provider share of this, and certainly, in many instances, what will happen is, these are services or activities that simply won't occur, because they were services that Medicare should not have been paying anything for.

Chairman **Stark**. OK. What you're saying is, in 5 years, on balance, the system, the providers and the people, either through the people having less incentive to go and get this medical care because it costs them more or the providers, are going to save $53 billion.

Dr. **Desmarais**. Not the $53 billion, because as you have observed——

Chairman **Stark**. $3 billion is going to come out of the third party, then. What do you say?

What I'm trying to get at is, what I suspect is that what you're expecting us to accept is that between zero and $5 billion is supposed to be saved in the system because we pay it less.

Dr. **Desmarais**. Well, let me give you an example. In the physicians——

Chairman **Stark**. No. Give me the example in a minute. But is that the thrust of what you are suggesting will happen?

Dr. **Desmarais**. I'm not prepared to tell you exactly where every penny is going to come from. There are so many things going on in the system that——

Chairman **Stark**. But that's the only place it can come from. Haven't we just decided that?

Dr. **Desmarais**. Yes, but you've covered a multitude of things that can occur, efficiency changes and trying to ascribe exactly what the value of that is at this hearing, I don't think I'm prepared to do that.

Chairman **Stark**. Look, I'm trying to get back to the $53 billion you're saving, OK. That doesn't come out of thin air, you know. This is not an Alice in Wonderland sort of world.

It is conceivable that it comes out of less usage or a more efficient system. You could take each particular procedure and give me examples, but I'm saying when you get down to it, you take the third party money over here, but other than that money—and if you want to quantify that, we could add it into the formula. But I'm saying that other than that, I don't see where it comes. It comes from more efficiency or less service, either because people won't get it or they don't want it.

What have we left out of the system in a broad brush? Anything?

Dr. **Desmarais**. I think throughout our discussion we have covered just about everything.

Chairman **Stark**. OK. So I come back that if you feel that third party payers, and I would include in that people who are just going to come up with more money out of their own pocket—in other words, that is an option, obviously—but let's say that that is $10 billion more, and I suspect that is very high—they you are just really expecting the $43 billion or $8 billion a year is going to come out of a system that is now spending about, what, $70 billion?

So you are talking about 10 percent a year plus inflation, and if you assume that is 3, you expect us to agree with you that this system is going to improve at 13 percent a year in terms of its efficiency-usage coefficient or whatever you want to call it?

Dr. **Desmarais**. I believe the system can respond a great deal to the incentives, and we have seen exactly that under prospective payment.

Chairman **Stark**. OK. Now, if that is the case, and I really decide that I want to save money for the Government, why then couldn't the system absorb $100 billion in cuts? Why shouldn't we take your numbers and double them?

Dr. **Desmarais**. Well, we are certainly not recommending that.

Chairman **Stark**. Why not?

Dr. **Desmarais**. Well, we are recommending what we feel confortable in recommending. We understand that the recommendations in the proposal are not going to be easy to adjust to on the provider's part or anybody's part.

Chairman **Stark**. Who do you think it is going to hurt the most?

Dr. **Desmarais**. I think everybody will have to work at living within these kinds of proposals if they are enacted. I guess we are at the point of, well, what are the alternatives? Knowing what we know about the trust fund and its health, and certainly if there is no money in the trust fund, then the quality of care and all those things the beneficiaries expect are going to be rather problematic.

So I think we are trying to find ways of stretching the money, stretching the Medicare dollar, and we feel that what has occurred under prospective payment demonstrates that the old way of doing business, cost-based reimbursement, really wasn't the right way of doing business, and we have also got broad agreement that reasonable charge isn't the way to do it.

Chairman **Stark**. You don't have that agreement, I believe, in this committee, and I would ask my colleagues to join in. You have agreement that out of two systems, both of which are terribly inaccurate, that we might as well just use one system that is equally inaccurate, but it is not the situation of having one shoe off and one shoe on trying to juggle historic payment and prospective payment in the same system.

I don't think there is a soul alive that thinks that moving to 100 percent transition is going to be fair and efficient. It is going to be one system that isn't very good that we hopefully can correct and adjust rather than two, but I'm not sure that you will find us agreeing that this is going to save much. It is just going to be less subject to gaining, and it may encourage people to offer alternative ways of billing us for the services, but I don't think that you can say that.

I do want to come back to the idea of picking this number of $53 billion. Is that all you think you can squeeze out of the system? I mean I am trying to figure out how you got to that total savings. What did you do? How did you come to the idea that this $53 billion is enough?

Dr. DESMARAIS. Well, we looked at all the various proposals, and the proposals before you are not the total number of proposals people have considered and reviewed, and these were the ones that we settled on.

Chairman STARK. What were your criteria in accepting the ones you sorted through?

Dr. DESMARAIS. Well, we were looking first for things that we could accomplish under current law or other proposals that we believe Congress might find acceptable. I recognize——

Chairman STARK. You didn't consider whether it would hurt the beneficiary?

Dr. DESMARAIS. Yes, sir. I considered all of those things.

Chairman STARK. Give me just a quick dissertation on what you call your sort of minimum requirements for you to accept a cost saving proposal. What are the criteria without which you would not accept it?

Dr. DESMARAIS. Well, we are basically looking to understand the effect of the proposals and whether, in fact, there was—what rationale there was for the proposals, and understanding the impact of the proposals as best we could.

Chairman STARK. Yes, but are there any impacts you would not accept? That is what I'm trying to get at. What was your criteria for accepting cost cutting or income raising proposals as you went through? I know there were thousands more. We have seen them and heard them. What are the Department's criteria?

Dr. DESMARAIS. Well, we were trying to look for those that were reasonable, that would achieve savings, and that would have as little impact on the beneficiary as we possibly could achieve, and trying to find ways—for example, our capital proposal, things that I believe you have said yourself you believe ultimately we ought to change and reform the way we pay for capital. In a country that is terribly overbedded, where occupancy rates are low——

Chairman STARK. But let me ask you this. Did you ever consider how much of a poor person's income he should have to pay before they got medical treatment? Was that ever considered?

Dr. DESMARAIS. Well, we already have a policy on spenddown under the Medicaid Program, and Medicaid eligibility criteria and so on.

Chairman STARK. At HCFA? Is that one of the things you considered when you looked at these things, or are they just kind of general? My suspicion is, Doctor, and I don't want to be coy with you, but my suspicion is that you didn't have any policy, that you just said where can we jam this through without having an outcry from the public or Congress. And I believe that you went through each cost-cutting proposal and said can we get away with this without kind of bouncing it off——

Dr. DESMARAIS. No, Mr. Chairman. I respectfully disagree. Many of the proposals were either the subject of General Accounting Office recommendations, congressional hearings or other suggestions from the research community and findings of the Inspector General. I believe we had an empirical base upon which we advanced at least a number of our proposals. But I will agree with you there are no painless alternatives before us, and I think we are trying to do the best we can to stretch the Medicare dollar and to provide the right incentives in the system without dictating medical practice or how a provider should run its operations.

Chairman **Stark**. That sounds fair. It sounds like what you have done. You have cut $23 billion out of the pockets of the beneficiaries and $20 billion out of the hospitals, and the docs and pillmakers aren't paying much of this. If the numbers show your policy, that is clear.

Mr. Pickle?

Mr. **Pickle**. Mr. Chairman, I want to follow through on a question I asked earlier. I am sure that you are trying to advance the recommendation based on the best auditors and department figures you can give us, so we don't question that. I have a little difficulty, though, in understanding how you can, on the one hand, limit doctors' fees and then downgrade their MEI, and you say it is really a help.

I would ask you how many of the physicians are at the prevailing charge level now, and you said it was difficult to ascertain, yet you make a specific recommendation that you are going to affect those charges on the basis of the number of who would either be above or below the level.

I am asking you to give this committee an estimate or a figure of those physicians who would be above the prevailing level or who would be below it. So I want those figures. If you calculated on that basis and yet you don't know how many of them there are, it seems to me like you are kind of grabbing a figure in the sky.

So please give us those figures as soon as you can get them together for us.

Dr. **Desmarais**. Yes, sir, we will be happy to submit those for the record.

[The information follows:]

There is no simple way to estimate the percentage of physicians whose charges are above the prevailing charge levels. There are approximately 7,500 procedure codes in the payment system under which physicians can bill for services. A physician's charge may be above the prevailing charge level for some services and below it for others. For this reason, analyses have focused on the percentage of program payments determined by prevailing charges.

According to CBO estimates, in 1984, for the country as a whole, 55 percent of reasonable charges were determined by prevailing charges. In a recent Office of Technology Assessment report, data from a study of Medicare payments in South Carolina in 1983 were reported. According to this study, 43.2 percent of approved charges for all specialties combined were determined by adjusted prevailing charges. This percentage varied with respect to individual specialties from 14.6 percent for ophthalmology to 59 percent for family practice.

The Administration's decision to propose an adjustment to the Medicare Economic Index (MEI) was not based on the number of physicians whose charges were above or below prevailing charge limits. Rather, the Administration's proposal complies with the Secretary's statutory responsibility to use "appropriate economic index data" when determining prevailing charge levels. The current use of the housing component of the Consumer Price Index—instead of the more appropriate rental equivalence component—is not justified given that most physicians do not own the buildings in which they practice. Rebasing the MEI on rental equivalence will allow us to correct this serious historical overstatement of housing costs.

Mr. **Pickle**. Thank you.

Thank you, Mr. Chairman.

Dr. **Desmarais**. The problem we have in part is that a centralized data base in physician services is just something we are developing today, so our knowledge base is not as good as our knowledge about the hospital side of Medicare, where we have had a much better data base for many, many years.

Mr. **Pickle**. Your knowledge base may not be as good as you want it to be, but your timidity is not limited. You are still making recommendations without knowing.

Dr. **Desmarais**. Well, the actuaries, I am sure, made some reasonable assumptions. We will be happy to submit what we can to the committee.

Chairman **Stark**. Doctor, you have a proposal, you talked about cutting down the overprice procedures. Would you submit or would you support a legislative proposal for mandatory assignment in those areas?

Dr. **Desmarais**. Mr. Chairman, the administration has made very clear on numerous occasions that we do not support mandatory assignment. That position has not changed in the context of the fiscal year 1987 budget.

Chairman **Stark**. So that is one of your principles. In other words, you would reject any cost saving suggestion that incorporates mandatory assignment?

Dr. **Desmarais**. Well, it would have no cost savings for the Medicare Program to require mandatory assignment.

Chairman **Stark**. Well, if we lowered the price, it would, to what you think it ought to be. You are talking about——

Dr. **Desmarais**. That is a separate issue, which you may do without mandatory assignment, and it is the lowering of the price that achieves the Medicare savings, not the requirement of mandatory assignment. The issue of assignment, of course, is important to the beneficiary.

Chairman **Stark**. Well, the issue of assignment is that the part B premium has to go up to pay—I mean you can go in and out that door as often as you want, but you are in for a dime, in for a dollar. If you have mandatory assignment on an inpatient procedure, and you reduce the total amount, you get a budget savings, do you not?

Dr. **Desmarais**. Again, though, reducing the payment is what gives you the savings to the Medicare Program, not providing mandatory assignment. The assignment is important to the beneficiary. And of course——

Chairman **Stark**. But we can't reduce the payment to the docs, can we?

Dr. **Desmarais**. Pardon me?

Chairman **Stark**. We can't reduce the payment.

Dr. **Desmarais**. Yes, sir. We can reduce payment under current law, under inherent reasonableness.

Chairman **Stark**. What I am suggesting is that any program that includes mandatory assignment would not meet your criteria, is that correct?

Dr. **Desmarais**. That's correct. The administration has opposed mandatory assignment because of the concern about access, and also observing that assignment rates today are running at historic highs of about 68 or 69 percent, far above what they were only about 5 years ago, a 50-percent range, and it is somewhat surprising, given the fact, as you know, we have had a fee freeze in place since July of 1984.

Chairman STARK. Thank you very much, Doctor.

Our next witness is Theodore Marmor, professor of public management and political science from Yale University, who will testify on the overall impact of the $53 billion in cuts over the 5 years.

Ted, welcome back to the committee in somewhat more formal posture than we last met with you.

It has been our practice to confine the witnesses to a 5-minute summarization, but I would ask that, without objection, you be allowed to summarize your report at somewhat greater length, and why don't you proceed in any manner you are comfortable.

STATEMENT OF THEODORE R. MARMOR, PROFESSOR OF PUBLIC MANAGEMENT AND POLITICAL SCIENCE, INSTITUTION FOR SOCIAL AND POLICY STUDIES, YALE UNIVERSITY

Mr. MARMOR. Thank you, Mr. Chairman, for the opportunity to testify on the administration's Medicare budget proposals for 1987.

I want to say here that I am coming to you in two different roles. I am an academic who has studied this program for 20 years, and I am also what you might call a vicarious consumer of Medicare. My mother, who is a Medicare beneficiary, died last year of liver cancer after a 5-year struggle with that disease. Those experiences mean that I see Medicare from two sides: As both policy analyst, and as a person who for half a decade has dealt with the program on my mother's behalf.

It is on the basis of these experiences that I would like to say something about where Medicare came from in the light of these draconian proposals to transform it today. I particularly would like to call attention to the way in which the commitments made to the elderly earlier are threatened by most, if not all, of these proposals.

And finally, I want to say not simply what I regard to be misguided, mistaken, or mean-spirited about these proposals; I want to try to make some constructive suggestions that are feasible, fiscally responsible, and humane.

So if I may, could I turn just briefly to the highlights of my testimony. I assume that you really want me to emphasize those things that I take to be important and leave open time for your questions after that. Is that correct?

Chairman STARK. Ted, that would be appreciated, and without objection, your entire testimony and report, to the extent that you have it, will appear in the record in its entirety.

Mr. MARMOR. All right.

The first thing I want to say is that these proposed budget cuts, coming in the wake of 5 years of restraint directed toward the Medicare Program, constitute, in my view, a near travesty in rejecting the commitments toward Medicare's beneficiaries.

Now, it is fair to say in looking back at the past that 20 years ago there was a considerable amount of humane impulse toward the elderly resulting in political compromise, which produced the part A and part B programs we call Medicare. I think I share with the administration a conviction that after 20 years, much in this program, while very good, needs reform.

So although in the context of budget hearings one would not ideally want to suggest reforms to Medicare, I welcome the chance to discuss seriously what sorts of reforms Medicare needs at a time when fiscal strain is evident.

But if you go back to the original intentions, it seems to me our aims in 1965 were to make sure that America's elderly had less fearfulness about the financial consequences of illness when they were older and likely to be sicker and likely to be less employed.

Now, much about the program has not accomplished that end, but that was the clear aim in mind. And if you contrast that end with the bulk of the budget cuts that are proposed today, what you see is that very little is proposed which underwrites the protection against financial catastrophe. Indeed, what it does is mostly shift costs to the elderly.

Let me go on to say something about the pattern of proposed budget cuts that have been presented since 1981.

They are comprised of four main elements. The preoccupation of Medicare policy of this administration over the last 5 years has been to reduce public outlays for Medicare. The preoccupation of the administration has not been to restrain inflation in medical care. It has been to reduce the budget for Medicare. That is evident in the testimony of the gentleman who preceded me today.

The preoccupation, indeed what you might call the obsession, almost a maniacal obsession, is to reduce the size of Medicare outlays quite independently of its impact on the rest of the medical care system.

The second preoccupation of these and earlier proposals is to accomplish this reduction in Medicare's budget primarily but not exclusively by reducing benefits going to older Americans by increased cost sharing when they are sick.

Third and very importantly, this administration has been preoccupied over the last 5 years, illustrated again today, with trying to reduce the payments going to providers, first in the hospital area and today much more on the physician's side.

There is a fair amount of controversy in this last area in the administration's health record. There is controversy over the extent to which the prospective payment system has produced benefits for the rest of American medicine. There is some controversy over how much of the reduction in Medicare's estimated outlays have come from the proposed budget or from the hospital prospective payment system, and there is some controversy over the consequences for old people, of the impact of Medicare's prospective payment system.

The discussion this morning about paying physicians and changing the way by which they are going to be reimbursed for excessive care is a relatively uncharted area.

Fourth, and the last point I want to make characterizes all these proposals and in some respects, it seems to me, weakens them most severely, at their core intellectually. The fundamental premise of most of these proposals is that America's elderly are overly insured for medical care, and what you need to do is to reduce the excessive protection they have so as to get them to use less medical care.

With those four elements, I think you produce the package of benefit cuts and other changes that have been presented to you this morning. While I would be prepared to talk at length about any one of them, let me just say a few words about what I would think is a more sensible way to address the question of what changes Medicare ought to have.

Let me take first the preoccupation with beneficiary cost sharing as a way to rationalize the benefits in Medicare and save outlays in the process.

The previous testimony suggested that research supports the view that increasing cost sharing is a splendid way without harm to reduce Medicare's budget. Research does not establish that. I can't be sure what research the gentleman was using. I am sure there are no unequivocal research findings that establish that. You have a dilemma with cost sharing with which I am sure all of the subcommittee's members are familiar.

If you make the cost sharing significant, that means a lot of people who are sick won't get care. If you make it trivial, it won't have any effect on the care given or costs incurred. There is no way to assure through cost sharing that the only care that is rationed is the care that is not needed. There is nobody in the western industrial world who on the basis of research can defend the proposition that cost sharing can in some social engineering way select out only that which is unnecessary.

There is a second point to be made. What we need to do in Medicare is reduce cost sharing, not increase it. We have a crazy quilt of provisions in our present law which do a lot of harm and not a lot of good.

For example, you heard the suggestion that we ought to change the way by which we pay for physician services. We are told to shift it around: to reduce the unnecessary care and increase the payments going for necessary care. At the moment we have an absolute mess in the way by which we pay for physician services under Medicare. We use words like "prevailing," "reasonable," and "customary," and they make no sense to older people out in the world.

Somewhat less than half of American physicians choose to accept what Medicare will pay. I am not saying that every payment by Medicare now is the right one. If we accepted mandatory assignment as a principle, we would be forced to the bargaining table with physicians, to try to rationalize paying too much for foolish things and paying too little for important things.

As long as you are wedded, as this administration is, to the conviction that mandatory assignment is wrong, what you do when you increase cost sharing and squeeze physician fees is you increase the payments made by older people or they don't get the care.

This is in some ways an orgy of cost shifting, not a systematic and well thought out device to produce rationalization of the benefit package.

Let me take another one. Let me just take one illustration, Mr. Chairman, that captures directly, I think, what is so wrong-headed, misguided and mistaken about what you have been hearing: the brilliant proposal to postpone eligibility by 1 month. There is an example of what I would call trivial reform. It accomplishes nothing in the way of reforming American medicine, but it is the kind of obsessional behavior of an accountant who wants to put money from one pocket or one ledger into another. What would it accomplish, Mr. Chairman, if you postponed by 1 month the eligibility for Medicare?

They suggest that something like $200 million-plus will be saved. To whom and for what? Saved because care would not be given? No. Their answer is most of those people are now covered by private insurance. That means there is simply a shift from the Medicare budget to a private employer's budget.

I see that I have provoked some discussion. Perhaps what I should say is to suggest that when you turn to reducing provider payments, which of course is a source of another large part of these reductions in the estimated rate of increase in Medicare's budget, you need to know that the suggestions in prospective payment that are made will not necessarily restrain overall medical inflation. The problem of cost shifting is serious there, although I am not against it. Second, we know that a physician freeze is to end in 1986. We also know that the reductions for selected high cost procedures will be likely to reduce access to some elderly unless coupled with some bargaining power on the part of the Government to insist that what the Government pays is accepted.

If I were thinking about the future, I would ask three questions. I would ask what are the most significant problems of American medicine generally, at a time of budget pressure, that we need to take into account as we adjust our Medicare Program? Second, I would ask on what basis can we find changes in the Medicare Program that will place the burden of reduced resources on those able to bear them the most and avoid it on those able to bear them the least? Third, how can we move in a direction so that 5 years from now we are closer to the aim of Medicare at the outset, which was to reduce the financial fears of illness in the years after 65?

My suggestion to you would be, in conclusion, that most of what you heard this morning would not move in that direction. I would suggest that if you wanted to move in that direction, you would do three things.

One is that you would reduce copayments at the time of illness and you would consider making some adjustments on the premium side as a balancing fiscal effect. That substitutes prepayment for uncertain payment when you are ill. Second, you would set a maximum liability for each elderly person per year so that the catastrophic consequences of a variety of costs would never add up to anything as frightening as they now add up. Something on the order of $1,000 per year might be in the ballpark, but many people would disagree about the precise limit. The third thing I would do is tell the American people the truth: to the extent that budget pressures suggest that we can't, out of our current budget, supply the sort of medical care we think is appropriate for the elderly under terms that seem sensible, we may be forced to seek new revenues.

I would suggest that the direction you would want to look at would include increases in both premium revenues and in Social Security taxes, based on the argument that every study of American public opinion that I have looked at suggests that when you are forced to choose between useful care and cost, Americans are prepared to pay on behalf of the elderly.

Thank you very much.

[The prepared statement and supplementary materials follow:]

TESTIMONY

OF

THEODORE R. MARMOR
PROFESSOR OF PUBLIC MANAGEMENT AND POLITICAL SCIENCE
INSTITUTION FOR SOCIAL AND POLICY STUDIES
YALE UNIVERSITY

Thank you for the opportunity to testify on the Administration's Fiscal Year 1987 Medicare Budget Proposals. I am here today in two roles: as an academic who has studied the Medicare program over a 20 year period and as a vicarious (albeit involuntary) consumer of Medicare's services. My mother, a Medicare beneficiary, recently died of liver cancer after a five-year struggle with the disease. From these experiences I would like to sketch briefly the evolution of the Medicare program and talk to you about the commitments made to the elderly which are threatened by these budget proposals. Finally, I want to present some ideas on Medicare program reform that would protect the elderly and disabled from the financial consequences of ill health and assure their continued access to decent health care within reasonable cost constraints.

I. Medicare's History

Today, Medicare, like American medicine, is in trouble. Costs have risen sharply for twenty years and continue to rise faster than the general cost of living or governmental revenues. Coverage has been eroded and the present benefits leave millions of the elderly confused, disappointed, and at risk for the catastrophic financial burden of chronic illness. Even at $60 billion a year, Medicare pays less than half the medical expenses of America's elderly. For six years, the program has been threatened with budget cuts, but Congress has resisted the Administration's most substantial changes. With the deficit dominating public policy, Medicare has returned to center stage. And the future, cloaked in changing estimates of impending "bankruptcy," frightens millions of present and future beneficiaries.

All of this is taking place in a context far different from that of Medicare's birth in 1965. Twenty years ago the question was how Medicare could bring the elderly into the mainstream of American medicine. Medicare originated as a federal program mediated by the non-governmental insurance industry. By the mid-1960s, bargaining with providers won support for a program which many — especially doctors -- had strongly resisted. The result was a universal, compulsory hospital insurance program for social security beneficiaries over 65, topped by a Federal Employees-style Part B that covered physician's services on the model of a commercial health insurance plan, complete with beneficiary deductibles, co-insurance, choice of extra billing, and administration by a fiscal intermediary.

For twenty years we have lived with the broad outline of this 1965 legislative result. Briefly put, that history is one of rampant medical inflation, the erosion of Medicare coverage despite growing real program costs, and persistent defense of the program against drastic budget cutting in the 1970s and early 1980s.

Two decades of relative medical inflation have swelled Medicare's outlays despite benefit erosion. The costs of health care have increased much faster than have the incomes of the elderly. Between 1970 and 1982, the mean real (inflation-adjusted) income for Americans over the age of 65 rose 20%. During the same period, inflation-adjusted co-payments for the Medicare program rose 84%. Co-payments and premiums combined increased by over 70% after controlling for the effects of inflation. Thus, as a proportion of their incomes, the elderly's average contributions to the Medicare program have increased steadily over time: from about 3% in 1970 to about 5% in 1980.

The stagflation of the past decade, however, has exacted another, perhaps more crucial, price. As the program matured fiscally, the energy that attended its origins has dissipated. The clear vision of its promoters called for step-by-step expansion once the fundamental legitimacy question of 1965 was settled. Instead, ever since the Vietnam War's escalation, benefit expansion has proven near impossible and the energies of the Medicare elite have gone into program protection. One result of this is a weakened sense in the diverse publics of American life of what precisely Medicare was for and why it is that Medicare, like Social Security, should not have its benefits reduced at a time of fiscal strain.

Reformers of Medicare used to aspire to bring needed medical care to the elderly, the disabled, and the poor. Now they focus on how to cut programs, which public facilities to close, whom to fire, what populations to neglect. Expanding resources for health used to create jobs and better and more accessible services. Now, as prices continue out of control, those who need access to care the most—the sick, the disabled, the elderly, and the poor--are hurt the most. Nowhere is that more vividly illustrated than by the responses to the worsened health inflation of the Reagan era.

II. Reagan Administration Budget Cuts: Impact on the Elderly

The Reagan Administration, like everyone else, laments rising medical costs. But they approach control of these costs perversely. They are obsessed with restraining the costs of public programs, not reducing medical inflation. They pay providers less for Medicare and Medicaid patients and, as a result, shift costs of public programs to workers covered by private health insurance. To cut government expenditures they use benefit cutbacks, reducing the number of persons eligible for public programs and shifting costs back onto the sick.

The result has been a noticeable weakening of both Medicare and Medicaid. Because of new federal and state policies, increased numbers of poor people are denied Medicaid eligibility and the care they need. The costs and burden of providing some essential care are thus shifted to local governments and hospitals, with "uncompensated care" a serious issue in some locales. The Reagan Administration invokes the idea of excessive use of medical care by the elderly, the disabled, and the poor as partial justification for budget cutbacks in Medicare and Medicaid. In fact, as much as 70 percent of the cost increases are apparently caused by price increases by hospitals, physicians, and other providers of care, not increased utilization of services.

This budget-cutting approach — largely, but not exclusively Republican — is wrong. It is premised on the misguided faith that "market" incentives are mostly what is needed to reduce costs in the medical world. Benefit cutbacks, in this view, serve both as required reductions of federal expenditures and as proper sources of price signals in medical care. The aim is to reduce access in order to lower government expenditures. The proper policy should control costs to make access to a decent level of care possible for all Americans.

Since 1981, the Reagan Administration's health policy has been marked by four elements which remain unchanged in this year's proposals: reduced public medical budgets; reduced benefits and more cost-sharing by recipients of publicly-supported care, a large number of whom are elderly and many of whom are poor; cutbacks in payments to Medicare providers; and an adherence to the belief that excessive insurance drives medical inflation, at the expense of all other issues.

A. Public Budget Cuts

Legislation passed in 1981 and 1982 reduced Medicare spending $22 billion below what it otherwise would have been. While Democratic opposition prevented the enactment of many of the strongest Administration proposals, the cuts were still significant. Further, according to the Congressional Budget Office estimates, one-third of these cuts came at the expense of the elderly and a disproportionate amount from families with incomes of less than $20,000. The Administration is now requesting an additional $4 billion in 1987 above; a full 35 percent of this burden will be borne by beneficiaries.

B. Reduced Benefits & Increased Cost-Sharing

The Administration's insistence that the elderly pay higher premiums and deductibles for physician services reflects a belief that cost sharing by the elderly is an effective inflation control. Yet Medicare patients already face significant cost sharing: the elderly now receive coverage of only 45 percent of their medical financing costs from Medicare. If cost sharing were such a powerful constraint, we would have already seen its effects on Medicare's budgetary growth and on the health spending of the elderly. Instead Medicare costs have sky-rocketed: in 1983 they increased thirteen percent, more than three times the rate of general inflation. This was due largely because of price increases by physicians, hospitals, and nursing homes and not because of increased use. There is evidence that making patients pay more at point of use (higher deductibles or coinsurance) will reduce total medical costs with few negative health consequences in the short run. Even if one assumes that these findings apply to the elderly, the already high, out of-pocket burden on the elderly would have to be drastically increased to reap those theoretically achievable savings.

C. Theory of Excessive Insurance

The view of medical inflation that the more one pays out-of-pocket for medical care, the more efficiently the system works flies in the face of most evidence. Utilization has played a small role in driving up the cost of Medicare.

Currently, more than half the elderly purchase supplemental insurance to protect themselves from Medicare's incomplete coverage. Since the poorest beneficiaries are the least likely to buy supplemental insurance, increasing Medicare deductibles and coinsurance would hit hardest the people least likely or able to bear the additional burdens. At the same time, unless supplemental insurance is outlawed, the hypothesized financial savings are unlikely to materialize. Most patients would still not face the financial consequences of seeking and receiving care and so would not reduce use.

Even outlawing supplemental insurance would not, however, produce the full cost savings proponents claim. Over 30 percent of Medicare expenditures are for financially 'catastrophic' episodes. Once the patient's deductible and coinsurance were paid there would be no further financial constraint on the patient to limit care. Other controls would still be required in order to restrain the very large costs from 'catastrophic episodes'.

The theory of excessive insurance is academic rhetoric for blaming the victim. It conveniently ignores how crucial the decisions of providers are to the bulk of the medical inflation problem. And the theory's celebration of cost sharing is dangerous encouragement of practices that can really prevent early diagnosis and useful care.

D. Reduced Payments to Medicare Providers

The Administration's proposals to reduce the rate of increase in Medicare's hospital payments promise insufficient help in restraining overall medical inflation.

Federal reimbursement policies toward Medicare's hospital charges changed dramatically in 1983. The Congress adopted the Administration's prospective hospital payment method for Medicare, in which payments per patient discharged are determined in advance as billed, rather than being based on costs determined after care has been provided. This new system is designed to function around the so-called "diagnosis-related groups" (DRGs). Using the DRG form of payment, with which New Jersey has experimented for some years, the Medicare program now pays fixed prospective rates for specific diagnoses (e.g., diabetes mellitus, arteriosclerosis).

There are three difficulties with this seemingly helpful step. First, restricting prospective rates to Medicare alone creates incentives for hospitals to shift costs to privately financed patients. To the extent such cost shifting is accomplished, it reduces Medicare's expenditures, not medical inflation. Second, to the extent hospitals are unable to shift Medicare's costs to other payers, Medicare patients are likely to become less welcome. As a result, the elderly's access to hospitals may be restricted as Medicare's prospective payments to the nation's hospitals tighten. This may be even more true for the sickest patients with the most complex medical problems. Restrictive payments by Medicaid have already reduced the access of many poor Americans to health services. Restricting Medicare or Medicaid program expenditures alone is no substitute for the containment of all medical care costs. Third, even efficient hospitals will be placed in financial jeopardy if they serve large numbers of government-sponsored or indigent patients.

The Reagan Administration's policies unfortunately offer neither long-run solutions to projected deficits in the Medicare Hospital Insurance Trust Fund nor to the problematic continuation of increased premiums. Even if all of the proposed 1987 Medicare cuts were enacted, Medicare insolvency would not be significantly delayed. Moreover, the temporary freeze on physicians' Medicare fees will end next month, and physicians will then be free to raise their fees again. The Congressional Budget Office estimates that, over the period from 1984 to 1989, Medicare spending will rise from $64 billion to $114 billion, an increase of more than 12 percent per year. On the other hand, the Social Security cost-of-living adjustments, which are supposed to permit the elderly to pay for Medicare's rising out-of-pocket costs, will increase by an estimated 5 percent per year.

The Administration continues to respond to increased medical care prices and government expenditures by proposing cuts in benefits and shifting of costs. This approach to health delivery for the elderly and disabled will only result in short-term Federal savings at the expense of the beneficiary's health and financial viability. The Administration's budget proposals are a travesty to the original objectives and commitments of the Medicare program to protect the nation's aged from the debilitating fiscal effects of acute illness.

III. A Prescription for Medicare's Future

Despite its accomplishments, Medicare is in trouble. But concerns about the program's impending bankruptcy divert attention from the real problem. The real choice is not whether to raise taxes or cut benefits, but whether to apply a Band-Aid solution -- and let Medicare's deficits recur -- or to get at the root of the problem and bring health-care inflation under control. I would suggest a different approach to the present administration model for health policy.

Every industrial nation is struggling with rising medical care costs. In the United States we have arguably one of the worst combinations of inflation, incomplete insurance protection, and inadequate bargaining arrangements for restraint. The experience of our northern neighbor, Canada, which has had a publicly funded, universal, national health insurance program in place since 1971, is instructive. National health insurance is supposed to drive costs through the roof. But a look at the Canadian record suggests that such need not be the result. Spending on medical care in Canada and the United States was roughly equivalent in

1970: 7.3% of the GNP. By 1982, Canadian spending was 8.4% of GNP, compared to 10.5% in the United States, a 20 percent difference per capita. Had our cost controls been as successful as Canada's, the United States would have spent $64 billion less in 1982 than the $322 billion actually expended. These differences are substantial and the comparative "excess" spending increases each year.

The example of Canada shows that runaway medical inflation is not inevitable among western democracies comparable in wealth, political structure, and medical tradition to the United States. We need an American equivalent of Canada's successful program. In constructing such a cost control alternative, we should first ask what principles of reform decent overall health policy should reflect.

A. Principles of the Plan

A sensible plan for cost containment should reflect at least three principles:

1) control the overall costs of medical care rather than public outlays alone;
2) find and encourage ways to promote more efficient, more effective, more appropriate, and more accessible care; and
3) avoid bias against vulnerable individuals and health institutions and seek fairness in program implementation.

B. Elements of the Plan

The health policy I propose would contain the following elements: control of overall costs of medical care, simplification of Medicare's administrative structure, and reform of Medicare's benefits.

1. Cost control

The plan I propose to control overall costs of medical care contains a number of different, related elements.

Target national budget

First, as an important temporary measure, the Congress could set a target "national budget" for medical expenditures. Such a "budget" might provide for overall national health spending at a rate equal to the previous year's outlays plus general inflation only. This would be shared on a 75-25% cost basis with the states. The state share might be financed through greater federal responsibility for Medicaid long term care and through greater state control over all provider contracts. Such a fixed limit should last only until more permanent cost-constraints could be negotiated with providers. The past inflationary spiral has gone on so long and proved so durable that forceful, no nonsense anti-inflation restraint is necessary. Experience teaches us that short-term price controls, across-the-board, can be reasonably effective. But it also teaches us that flat lids fail unless replaced by more flexible measures--like bargaining deals--over time. Perhaps equally important, such temporary restraints should convince the medical industry of the seriousness of cost control and give it the necessary incentives to negotiate sensible rates of payment for the industry as a whole. This spending cap would express the need for bold action and would encourage providers to make the transition from the current relatively open-ended system to a system with negotiated payments.

State cost-control plans

State cost-control plans, within a framework established by the federal government, are the second programmatic element for stopping the destructive inflation in medical care. Clearly there should be fair payment to hospitals and other health care providers by Medicare, Medicaid, and private health insurance. But these payments should be based on what is required for decent medical care, not whatever hospitals or physicians want to charge.

Having federal or state governments prospectively establish medical care expenditures is a necessary step toward stopping medical inflation and assuring fair payment by and to all parties. Precisely which unit of government is best suited to this bargaining role should be debated. The federal government has the largest single stake in controlling medical inflation, but little direct experience with negotiating across the nation with this large, complicated industry. The states, which would have a new 25% financial stake in Medicare spending, have more relevant experience with from their regulation of Medicaid and other state programs. Within guidelines established by the federal government designed to assure access to quality care as well as accountability for provider payments, states would be the sensible unit of government for this purpose.

Every other industrial nation recognizes the necessity of negotiating the level of resources going into medical care. It is time the United States did the same. Neither slogans about "competition" and the "market" nor "voluntary efforts" by the medical care industry will stop medical cost inflation. New methods of organization like Health Maintenance Organizations or Competitive Medical Plans will not, by themselves, stop medical cost inflation. Nor will regulatory approaches such as Certificate of Need, Professional Review Organizations, or Prospective Payment Systems, by themselves, stop medical cost inflation. Our commitment to bargaining represents a break with two decades of searching for easy and automatic solutions to medical inflation. It represents an acceptance of continual negotiations with health providers to decide how the country can restrain spending on medicine without sacrificing quality or fairness.

Health professionals, hospitals, nursing homes, and private health insurance companies ought not have the monopoly on deciding how much society spends on medical care. They do, of course, have crucial expertise both in providing care and understanding how to restrain wasteful practices in our pluralistic society. A democratic political process, informed but not monopolized by interested professional parties, must separate the question of acceptable expenditures from the question of what care patients ought to receive without budget limits. Decisions about the proper practice of medicine largely rest with health care professionals and their patients. But public policy decisions about how much the nation spends on medical care should be informed by continuing dialogue with health professionals and medical institutions, the health insurance industry, and the various affected publics, not determined by the industry alone.

All Payers

I recommend that all payers -- Medicare, Medicaid and private insurers -- be placed within the purview of the state cost control plans. The incentive for all payers to check the waste and inefficiency in medical care will thus be reinforced by a uniform state-wide payment maximum.

2. Simplify Medicare Administration

Costs are not Medicare's only problem. While successfully protecting the elderly from the financial burden of most hospital bills, Medicare has also left them with a complex system, far from complete, perverse in its incentives, and frequently confusing in its options. To remedy these problems, I propose that Medicare be reformed as follows: 1) Permit the states to administer Medicare and Medicaid from one agency; 2) Combine Medicare Parts A and B; and 3) Provide for Medicare benefit representatives to be located in local Social Security offices.

States, through their efficient administration of the Medicaid program, have succeeded in reducing the annual rate of increase of Medicaid expenditures from 14% in 1981 to 9% in 1984. This built-in state efficiency could be expected to have a similar effect on Medicare cost increases, which have been close to 13%.

Medicare's separate Parts A (mandatory hospital insurance) and B (optional supplementary medical insurance) are the products of compromise, accident, and inertia, not of considered planning. Today the split between Parts A and B makes Medicare needlessly complicated in operation and confusing to its beneficiaries, 97 percent of whom elect Part B coverage. I think Parts A and B should be combined into a single unified program, enabling Medicare to offer older Americans a uniform structure of benefits and cost-sharing requirements. This consolidation will make it easier for beneficiaries to identify and contact one responsible agent.

It is essential for America's elderly to have an advocate and a source of information in dealing with medical providers and the Medicare program. As efforts to control costs through prospective payment increase, larger numbers of Medicare beneficiaries will find themselves denied treatment by providers. As the number of HMOs participating in Medicare increases, our old will be faced with an increasing array of options in coverage and copayment. Under such circumstances, beneficiaries much have somewhere to turn. I therefore suggest that HCFA establish a Medicare ombudsman's office within each Social Security office. The ombudsman's role would be to provide beneficiaries with information on their rights and options under Medicare and to monitor and review beneficiaries' access to care.

3. Benefit reform

a. Promote Efficiency in Health Delivery Systems: Create a Medicare Part C to Encourage Capitated Systems

It is not institutions alone that shape our medical practices and determine how much we spend. Health professionals--especially doctors--play a large role in this, and thus ought to participate in feasible cost control plans.

Cost control programs should, therefore, reward physicians and patients for reducing inappropriate and unnecessary care. The incentives for excessive care inherent in fee-for-service reimbursement must be counterbalanced. Group practice prepayment plans, HMOs generally, and other capitation systems have been expanding rapidly in some areas and have been successful in assuring adequate, but not excessive, care at a reasonable cost. These should be strongly encouraged through the creation of a Medicare Part C. This new administrative structure would serve to promote and finance more efficient delivery systems, such as HMO, CMP and other capitated systems. It would also tend to shift Medicare exenditures away from "high-tech" care towards more effective preventive and primary care.

The current system has more than enough capacity to provide a decent level of medical care for all Americans. The United States does not need to cut back medical services arbitrarily and unfairly, nor to ration care by ability to pay, as the current trend would imply. But the American medical care system does need to be restructured to reduce unnecessary and inappropriate care that is increasingly costly.

b. Catastrophic Coverage

All of these reforms would be a significant step toward assuring Medicare's delivery on its promise to protect the elderly. But they would, however, still leave the elderly exposed to potentially catastrophic expenses. Cost sharing on physician services and hospital care--even when charges are limited—can mount up sizable bills for the very ill. The threat of financial ruin could be dispelled, at a relatively small cost to Medicare, by limiting each beneficiary's total annual liability for payments to $1,000 (indexed to Social Security cola).

IV. Summary

Let me summarize the six elements of a reformed health policy that bear crucially on Medicare's problems.

1) National Target Budget

Set a targetted national budget for Medicaid expenditures to be lifted as permanent cost-constraints are negotiated with providers.

2) State Cost Control Plan

Require states to administer Medicare as well as Medicaid within a guideline established by the federal government to assure access to quality care and accountability for payment standards. States could share 25% of the costs of Medicare and Medicaid with the federal government in return for federal assupmtion of their long term care expenditures.

3) All-Payers

Put all third party payments within the purview of the state cost control plan.

4) Promote Efficiency

Encourage the proliferation of capitated health delivery systems, including HMOs. Shift the focus of expenditures from "high-tech" health care to preventive and primary care through negotiated provider contracts.

5) Simplify Administration

Reform Medicare administration as follows:

- Permit the states to administer Medicare and Medicaid from one agency
- Combine Medicare Parts A and B
- provide for Medicare ombudsmen in Social Security offices to serve as advocates and sources of information for beneficiaries.

6) Benefit Reform

- Create a Part C for HMO and other pre-payment plan subscribers
- Provide Catastrophic Coverage: permit beneficiaries to purchase catastrophic coverage for acute care in lieu of Medigap policy, and limit individual annual liability to $1,000.

V. Conclusion

As an academic and student of Medicare over twenty years, I have watched this public program accomplish much for the elderly. I now see these accomplishments threatened by the piece-meal budget ax approach of this Administration. I hope that my testimony today has convinced you that the protections afforded the elderly in the original law can still continue. I urge you to re-think this program without reneging on the commitments made to this nation's elderly two decades ago. I believe my package of reforms are doable. They also contain values that are explicit and whose expression is for those who — through age or illness — are less able to speak for themselves.

Material to Supplement Marmor Testimony
of March 6, 1986
before the House Ways and Means Health Subcommittee
on the Medicare FY 1987 Budget Proposals

This is to supplement my testimony of 3/6/86 before the House Ways and Means Health Subcommittee on the Administration's Medicare FY 1987 Budget Proposals. I want to assure the Subcommittee members that my testimony was not directed at past congressional action on Medicare. It was meant as review and analysis of the current Administration's approach to health policy and the Medicare program.

In this supplementary material, I want to outline my objections to some of the Medicare proposals contained in this Administration's legislative and regulatory package for Fiscal Year 1987. I will then follow with more detail on the elements of a reform strategy for Medicare, particularly administrative reform, that I could only briefly discuss before the Subcommittee on March 6.

ADMINISTRATION'S FY 87 MEDICARE PROPOSALS

The themes of this Administration's health policy since 1981 have not substantially changed. Rather than an intellectually sound plan for Medicare reform that meets cost-control objectives, we have seen a poorly directed assault (by the Office of Management and Budget) to slash Medicare expenditures. These reductions would come primarily at the expense of the program's elderly beneficiaries and private third-party payers who now finance a large portion of the elderly's care.

Increased beneficiary cost-sharing, for both Part A and Part B services, is posed at a time when Medicare services are already being reduced and the proportion of the elderly's total health care bill paid by Medicare has already dropped.

Medicare payments to hospitals and physicians are slated for dramatic reductions. These proposals come at a time when medical inflation continues to affect Medicare payments to providers under prior cost-control reforms. These past reforms have been a mixed blessing and tinkering with the hospital DRG formula and payments for selectively targeted physician procedures cannot, inherently, address the fundamental reform of Medicare provider reimbursement that is called for.

FUNDAMENTAL MEDICARE REFORM

As I mentioned in my testimony, Medicare has not been reviewed for fundamental reform over the past twenty years. I would propose that, in the present context of budget famine, Congress undertake such a review.

What I take to be the basis for a national reform program for Medicare is suggested in my written testimony. Many of these same elements are contained in the report of the Harvard Task Force on Medicare Reform, a summary of which was published in the New England Journal of Medicine on March 13, 1986 (enclosed).

The goal of any reform effort for Medicare should be a rational, coherent program regarding services covered, costs shared, administrative simplicity, and provider reimbursement while addressing and restraining the underlying causes of medical inflation.

Most importantly, the end result should be a program that is more intelligible and accessible to the public for which it was designed.

A. Summary of Reform Package

This Administration's approach to Medicare budget reductions shifts costs and reduces access to care for elderly beneficiaries when they are ill and at their most vulnerable. A fundamental reform package should, instead, contain the following elements:

- establish a national budget for medical expenditures, to rise with the Consumer Price Index or Gross National Product, not medical inflation.

- establish a system of state-administered and negotiated all-payer provider contracts that would take advantage of local and regional differences in the design and delivery of medical care;

- simplify administration of the program by combining Parts A and B, establishing Medicare ombudsmen and case managers to explain and coordinate program benefits, restricting beneficiary payments to a combined, fixed annual premium (offset by reduced co-insurance and deductibles) that would not vary with the illness of the beneficiary;

- afford the elderly increased protection against catastrophic illness by establishing a cap on total beneficiary out-of-pocket liability (e.g., $1,000 per year);

- encourage the proliferation of more effective medical care systems by creating a new Medicare Part C to promote and finance capitated systems such as HMOs and CMPs;

- finance increases in Medicare expenditures by progressively taxing the Social Security benefits of higher income elderly, or, possibly, by a small, flat tax on Social Security payments;

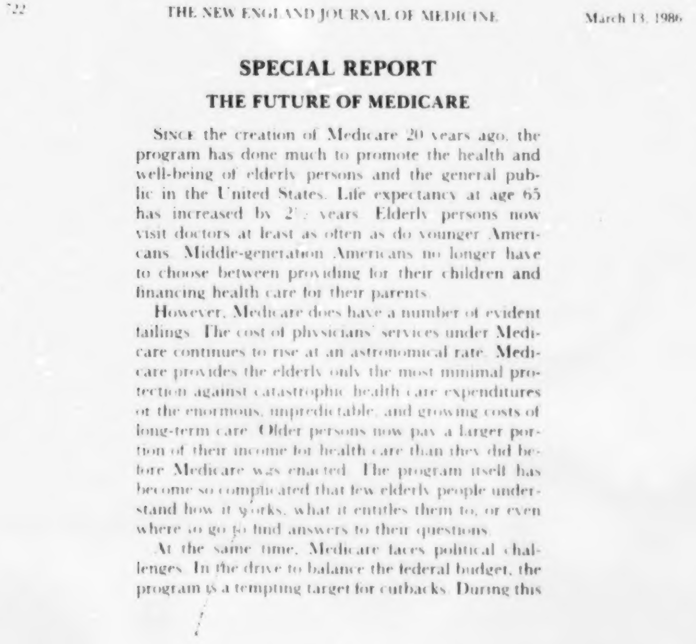
- begin a national discussion on expanded Medicare coverage of long-term care services.

B. Details on Administrative Reform

Although I believe that the reforms outlined above are crucial to the continued health of the Medicare program, my special concern is that the overall structure of this program be fundamentally revamped. Many elderly beneficiaries cannot begin to cope with the intricacies of claims processing, co-insurance payments, and appeals that this system requires. Providers are faced with complex reimbursement formulas, often foolish in their effect. And Congress must deal with a bloated structure of Part As and Part Bs, whose services and payment mechanisms are seldom intelligible.

I am proposing the creation of a simpler program, one that presents the beneficiary and provider alike with a combined set of services, reimbursed through negotiated contracts with state agencies, and one that begins to shift scarce health resources into less expensive primary care delivery systems. To this end, I am enclosing a second paper on Medicare admininstrative reform. I believe it describes a more rational Medicare program design that will assure the future success of this program in delivering needed medical care to the elderly while retaining popular support for its continued existence.

Attachments (2)



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SPECIAL REPORT

THE FUTURE OF MEDICARE

Since the creation of Medicare 20 years ago, the program has done much to promote the health and well-being of elderly persons and the general public in the United States. Life expectancy at age 65 has increased by 2½ years. Elderly persons now visit doctors at least as often as do younger Americans. Middle-generation Americans no longer have to choose between providing for their children and financing health care for their parents.

However, Medicare does have a number of evident failings. The cost of physicians' services under Medicare continues to rise at an astronomical rate. Medicare provides the elderly only the most minimal protection against catastrophic health care expenditures or the enormous, unpredictable, and growing costs of long-term care. Older persons now pay a larger portion of their income for health care than they did before Medicare was enacted. The program itself has become so complicated that few elderly people understand how it works, what it entitles them to, or even where to go to find answers to their questions.

At the same time, Medicare faces political challenges. In the drive to balance the federal budget, the program is a tempting target for cutbacks. During this era of government retrenchment, proposals have been made to replace Medicare with subsidized private savings plans and private insurance policies.

The participants in the Harvard Medicare Project saw the 20th anniversary of Medicare as an appropriate time to take stock of the program's successes and to make specific suggestions to meet the enormous challenges it faces. This report summarizes only the most important of our 40 proposals. A complete discussion of all our recommendations appears elsewhere.[1] Although we hope our findings will be relevant to issues now on the legislative agenda, we, as academics, have the luxury of taking a longer view. In the past, Medicare reform has too often proceeded in a piecemeal manner, driven by moments of crisis or by purely programmatic concerns. Too much of the current political debate has focused solely on cost control, as opposed to more general program improvement. Many of our suggestions indicate the direction we think Medicare should take over the next 10 to 15 years. We hope that history will bear us out and that these proposals will contribute to a broad-ranging debate about the future of this essential but troubled program.

PREMISES AND GOALS

Our analysis is predicated on one premise and three goals. The premise is that the government must continue to play an important part in ensuring that elderly people have adequate access to health care services and adequate protection against the costs of illness. Our goals are to promote cost control, fairness, and simplicity in the Medicare program.

As in other areas of social policy, it has become increasingly fashionable to address Medicare's problems with market-oriented solutions. We are neither opposed to private initiatives nor enamored of government. However, the special nature of older persons and their health problems argues for caution in relying primarily on private solutions to providing health care for them.

The Medicare program was enacted specifically because some elderly people were unable to obtain affordable private insurance. Today this problem is even more severe. The costs of health care have soared and private insurers face sharply increased competition, thus making them less able to subsidize unprofitable enrollees.

Even when options are available, older persons may be unable to reap the benefits fully. As compared with younger consumers, the elderly are often less capable of making knowledgeable choices about health care purchases and less able to change insurers or providers when dissatisfied. Partly because elderly persons are more likely to suffer from physical and mental impairments (declining eyesight, hearing, and memory), they have more trouble than younger persons in comprehending the increasingly complex insurance arrangements now available. The elderly also usually lack the counsel of the purchasing agents and benefits representatives who serve younger, employed populations.[2] Although some retired persons may be able to navigate our health care system, many others will not fare well in the rough and tumble of a health care marketplace.

Consequently, although we favor providing Medicare beneficiaries with more choices, we believe this can best be achieved by allowing them more options within the existing Medicare program and by encouraging a cooperative approach between the public and private sectors. Private health plans, such as health maintenance organizations (HMOs), can play a more active part in the program. However, the government must take an equally active role in making certain that the health care system provides the essential care that the elderly need. Recent reforms have demonstrated that Medicare can stimulate beneficial changes in the way we pay for health services (through prospective hospital payments) and in the way health care is delivered (for example, in hospices). Medicare should continue to have this role.

In discharging these responsibilities, the government should strive to achieve three goals. First, it is essential to contain Medicare expenditures. We are concerned not only about the current federal deficit; rather, cost control is a valuable objective in its own right, as long as it is achieved through changes that increase the efficiency of the program.

A second goal for the Medicare program is fairness — to the elderly, to health care providers, and to other groups (employers, insurance companies, and family members) who are affected by the program. The elderly should receive affordable health care that is comparable in quality and amount to that enjoyed by the average American. When cost considerations dictate limits on access to services or higher patient payments, the burden should fall more heavily on the healthy and the wealthy.

Medicare should end payment policies that treat providers in capricious or unpredictable ways. The program should also honor its broader responsibility to society. It should pay enough to cover the reasonable costs of caring for its own beneficiaries, and it should promote payment systems that discourage discrimination against any group of patients.

The third goal of the Medicare program should be simplicity. Medicare is currently composed of several parts, each with its own procedural requirements and appeals processes. Beneficiaries must deal with five different types of cost sharing and with seemingly arbitrary distinctions between covered and uncovered services. The Medicare program should be simplified so that both the elderly and their care givers can understand it.

REFORMS DIRECTLY AFFECTING BENEFICIARIES

Three aspects of the Medicare program have the most direct and immediate effect on its beneficiaries. The first is the amount patients must pay out of pocket at the time services are used — i.e., their copayment responsibilities (coinsurance and deductibles). The second is the nature of those covered services — i.e., what Medicare will and will not help to pay for. The third is the overall complexity of the program, which determines how easy or difficult it is for elderly people to use the Medicare program. Improvements can and should be made in all these areas.

Decreased Copayments and Increased Premiums

Present cost-sharing arrangements for Medicare patients are unfair and poorly conceived. During the past 20 years, the proportion of Medicare costs paid through copayments has increased, whereas that paid through premiums (which are required only for Part B) has fallen. Monthly premiums have increased from $3 to about $15, but copayments and overall program costs have grown more than 10-fold. Copayments disproportionately burden the poor and the sick, they have become excessive overall, and their unpredictability undermines the principles of insurance that Medicare was designed to promote.

Because there are no limits on accumulating copayment liability, the sickest elderly persons — those who use many services — face the steepest Medicare copayments. We have estimated that each year more than 2.5 million enrollees pay more than $1,000 in copayments alone.[3] Since copayments are unrelated to income, they add to the disproportionate burden of the cost of health care on the poor. Currently, poor and near-poor elderly persons pay 25 percent of their income annually for health care. For those with incomes that are three times that of the poverty level or more, the figure is 2.5 percent.[4]

Because copayment requirements are linked to the use of services, they are inherently unpredictable, and their unexpectedness is a major handicap for retirees with fixed incomes. As a result of the rapid inflation of health care prices, many forms of copayment — which are set as a fraction of medical charges — have also become excessive. During the past decade, the total amount that Medicare beneficiaries paid in copayments has risen 50 percent faster than their income.[8,9] Between 1985 and 1986, the hospital deductible alone increased by 23 percent. As a result, policies intended to encourage elderly patients to be prudent purchasers of care have become an important deterrent to needed treatment, particularly for those with the lowest incomes.

To lessen or eliminate these drawbacks, we propose reducing or eliminating several of Medicare's deductible and coinsurance provisions and increasing beneficiary premiums to make up the lost revenues. We believe that the aggregate contribution of the beneficiaries should be maintained at the current level of 25 percent of program costs. We find premiums inherently preferable to coinsurance and deductibles for three reasons: they are predictable, they do not penalize the sick, and they can be related to income.

Specifically, we recommend that Medicare's hospital deductible, which is currently equivalent to the cost of a day in the hospital ($492), be cut in half; that the physician deductible (now $75) be eliminated; that the requirement that patients pay 25 percent of the cost of each hospital day after 60 days of hospitalization be eliminated; and that the physician coinsurance requirement be reduced from 20 to 10 percent. An additional annual premium payment of $150 to $200 for each beneficiary would offset any revenues that were lost because of these changes, as well as the costs of any additional health care.

The two forms of copayments that we would eliminate do little to control the use of health care services; they only add to the amounts paid by elderly users of those services. Copayments for long hospital stays are no longer sensible now that Medicare's new prospective payment system creates incentives for early discharge. Physician deductibles do not curtail the use of physician services by beneficiaries (about 50 percent of Medicare recipients) whose chronic illnesses require that they see physicians frequently. These patients know that they will always spend far more than the deductible each year.

Even with the reduced provisions for coinsurance and deductibles, copayments will accumulate into large bills for very sick and chronically ill elderly patients who use expensive services extensively.[7] This problem can be eliminated at a relatively small cost to the program (approximately $500 million) by limiting each beneficiary's total annual liability for copayments to $1,000.

Premiums Adjusted According to Ability to Pay

Increases in the premiums paid by Medicare beneficiaries will disproportionately affect elderly persons with low incomes. To ease their burden, we propose, first, that uniform national standards be established for Medicaid's payment of Medicare premiums. Currently, because of varying state standards, only 25 percent of poor and near-poor elderly persons are covered by Medicaid, and states can refuse to purchase Medicare coverage (under Part B), even for those who are eligible to receive Medicaid. States should be required to purchase Medicare coverage for all older persons whose incomes are at or below 125 percent of the federal poverty level.

Second, to adjust premium contributions to the incomes of elderly people who are not poor, we recommend eliminating the extra personal exemption ($1,040) for all taxpayers who are 65 or over and assessing them a surtax that is equal to 5 percent of their taxes. The additional revenues raised in this way would be earmarked for the Medicare program. Because only slightly more than 40 percent of elderly persons pay any income taxes, most of the added funds would be collected from those most able to pay. Among those affected, elderly persons with higher incomes would pay more than those with lower incomes. These reforms would generate about $8 billion annually. The Medicare premiums should be reduced by a comparable amount.

Expanded Coverage of Long-Term Care and Chronic Illnesses

Even though about 25 percent of the health care costs of elderly persons are for long-term care, Medicare now pays only a small part of the cost of nursing-home care and virtually none of the outpatient care of chronically ill elderly persons that is provided by nonphysicians. For those who are eligible, Medicaid pays some of these costs, but its coverage is incomplete and varies greatly from state to state. In many states, elderly people must impoverish themselves and their households before they become eligible for the Medicaid program.

Our society cannot in good conscience continue to deal with chronic illness in this manner. It robs the elderly of their dignity and of any real hope of economic and emotional security. Although we recognize that private insurers have begun to experiment with plans that cover some of the costs of nursing-home care, there are three major reasons why those insurers fail to offer reasonably priced insurance for long-term care.

First, few people are willing to purchase coverage until they reach an age at which their chances of needing nursing-home care are quite high. For most persons of that age, private insurance for nursing-home care is too expensive; in fact, the premiums for those older than 70 can approach $1,500 a year.[8] Second, because private companies fear that covered patients will overuse insured services, many of them will not offer coverage for a full range of noninstitutional care, or they will price such coverage beyond the reach of all but a few wealthy persons. Third, the marketing of insurance on an individual basis, which is necessary for most retirees, tends to make the policies even more costly.

In many ways, the problem of long-term care that now faces elderly persons closely resembles the problem they had with physician and hospital services that led to the enactment of Medicare — the costs are high, the needs are pressing, and the response of private insurers is insufficient.

To address the issue of long-term care, we propose two major reforms in the Medicare program. First, Medicare should cover the cost of extended nursing-home care (in addition to the limited, rehabilitative stays for which it currently pays), which constitutes the single largest out-of-pocket expense for health care of elderly persons today. This coverage should be mandatory, and it should ultimately be financed in the same way as the rest of the Medicare program — i.e., through a combination of Social Security taxes levied on the working population, premiums paid by elderly persons, and general revenues.

Our proposal that Medicare cover nursing-home care in this fashion raises a number of legitimate concerns. First, much of the cost of a nursing home represents living expenses (room and board), and many consider payment of such expenses by Medicare to be inappropriate. We propose that Medicare beneficiaries in nursing homes cover such nonmedical costs by making "residential copayments" that are equal to 80 percent of their Social Security benefits.

Another concern is that covered nursing-home services will be used inappropriately and excessively. The proposed residential copayment will partly discourage overuse, but we also suggest that Medicare beneficiaries be required to pay a deductible for extended nursing-home care (beyond that currently covered by Medicare in full) that is equal to the cost of one month of care. Furthermore, we suggest that the Medicare program designate geriatric assessment teams of physicians, social workers, and nurses in each community to act as nursing-home "gatekeepers." All admissions to nursing homes will require advance approval from those teams.

Our second major proposal is that Medicare provide more generous coverage of long-term care in outpatient settings, especially of home health care and mental health services. Currently, partly because of limitations on Medicare coverage, mentally ill older persons are half as likely to be treated as their younger counterparts.[9] Outpatient coverage would reduce the incentive to institutionalize patients with chronic illnesses, either in hospitals or nursing homes, in cases in which less expensive outpatient care would suffice. Currently, for example, 10 to 30 percent of the elderly persons in nursing homes are there because they could not find adequate outpatient services.[10] To prevent the excessive use of these long-term care benefits, the community-based "gatekeepers" should also determine eligibility for those services.

Despite financial and administrative safeguards, an increase in coverage for long-term care and chronic illnesses would be expensive. Additional expenditures could reach nearly $15 billion a year (1985 dollars) within 10 years of implementation (Table 1). We think that these costs are justified, but to accommodate concerns about the federal deficit, we suggest that the new benefits begin in 1990, after current efforts to reduce the deficit have had time to take effect.

Improved Primary Care

Good primary care involves timely diagnosis and treatment. Eliminating the deductible on physician services, as suggested earlier, will remove an important barrier to such care. We also propose that Medicare cover the entire cost of an annual physical examination (no copayment by the patient). This visit should be limited to a set of specified, preventive screening tests, such as cervical Papanicolaou smears, blood-pressure checks, cholesterol determinations, rectal examinations, and stool assessments for occult blood. For persons who are unable to visit a physician's office, Medicare should pay a home health agency to conduct similar examinations.

Administrative Simplification

Many of the proposals discussed above would, if enacted, help to simplify the Medicare program for its beneficiaries. Their responsibilities for copayments would become simpler and easier to understand. The arbitrary coverage distinctions between acute and chronic care and between physical and mental illness would be eliminated.

To simplify the program further, we propose that Medicare's Parts A and B (which cover hospital and nonhospital services, respectively) should be combined into a single, unified program that would allow

Table 1. Projected Costs for Long-Term Care under the Current Medicare System, as Compared with Those of the Proposed Medicare Coverage, Beginning in 1990.*

TYPE OF CARE	YEAR		
	1990	1995	2000
	billions of 1985 dollars		
Under current system			
Nursing-home care	30.3	34.5	38.8
Outpatient long-term care†	5.3	5.9	6.6
Total	35.6	40.4	45.4
Under proposed system			
Nursing-home care‡	30.3	45.8	50.4
Outpatient long-term care	7.3	8.2	9.4
Total	37.6	54.0	59.8
Difference between current and proposed systems	2.0	13.6	14.4

*Sources are studies of impairment in elderly populations,[11] nursing-home use,[11,12] home health care use,[13,14] and the use of mental health services.[9,15]

†Includes home health care and outpatient mental health care.

‡For the 1990 projections, we assumed that nursing-home use would be limited by the available supply of beds. The supply is assumed to increase by 1995 in response to the following changes in use: 20 percent of those who would otherwise be in nursing homes remain in the community because of enhanced home care, all elderly persons who require personal care (e.g., feeding and dressing) and who are unmarried or living alone are in nursing homes, and half the elderly persons with impaired mobility who are living alone are in nursing homes.

Medicare to offer older persons a uniform structure of benefits and cost-sharing requirements. The existence of separate programs is the product of accident and inertia, not of planning. When Medicare was enacted, legislators simply assumed that the program would be modeled on existing private health insurance plans, which typically offered separate policies for hospital and physician coverage.

Reforms in Payment of Physicians

Current methods for paying physicians under Medicare have a number of drawbacks that contribute to escalating costs and the unfair treatment of both beneficiaries and physicians.

From the beginning, Medicare has reimbursed physicians according to the "customary, prevailing, and reasonable" (CPR) method.[16] For several reasons, this system has contributed to escalating costs. First, since it pays physicians on a fee-for-service basis, it creates a built-in incentive for physicians to provide more services. Since payment is based partly on what physicians customarily charge, the method has perpetuated the relatively high fee scales of specialists and surgeons, thus encouraging such physicians to provide more high-technology services.

The Medicare payment system is also unfair to patients in that it allows physicians to accept or reject "assignment" (that is, to decide whether to accept the fee set by Medicare as full compensation) on a case-by-case basis. Physicians who refuse assignment must bill the patient directly to get paid, but they may then charge more than the fee set by Medicare. In 1983, 10 percent of the out-of-pocket expenses for physicians' services of Medicare beneficiaries were payments for unassigned charges. Such expenditures add to the confusion of elderly patients, they impair access to care, and they vary arbitrarily according to the physician and the region.

The current system for paying physicians also tends to treat certain groups of physicians unfairly. Even when specialists and surgeons provide services that are similar to those given by primary care practitioners, they receive more compensation. In 1982, for example, specialists were paid 20 to 53 percent more for a brief office visit than were primary care physicians. Another example of unfair treatment is that physicians in urban areas are generally paid considerably more than physicians in rural areas.

To ameliorate these problems of cost and fairness, we recommend that Medicare pursue four major avenues of reform. First, the program should continue to encourage enrollment in prepaid health care organizations (see below). However, we recommend caution in implementing systems that reimburse individual physicians for ambulatory services alone on a prepaid basis under "managed care" arrangements. Without the financial resources and management expertise that are available to large organizations, individual physicians might not be effective in containing costs while preserving the quality of care.

As long as enrollment in prepaid health care organizations remains voluntary for Medicare beneficiaries, many — perhaps most — will continue to be cared for by physicians on a fee-for-service basis. Therefore, a way must be found to improve on the CPR method of determining fee-for-service payments. Thus, as a second major reform, we recommend that Medicare pay physicians according to a relative-value scale that is adjusted by a dollar-value multiplier.[17] A properly designed relative-value scale could help to control costs by making physician payments "fiscally neutral." It would reduce fees for certain services that are now expensive and overvalued under the CPR system (such as certain specialty services). Such a system would also eliminate unjustifiable differences in fees charged to beneficiaries and in those paid to physicians in different geographic regions.

Since any fee-for-service system encourages physicians to deliver more services, the implementation of a relative-value scale would not guarantee overall cost savings in the Medicare program. Thus, to ensure that such savings occur, we recommend, as part of a third major reform, that the federal government establish an annual target budget for total expenditures for physicians' services under Medicare. If payments exceeded that target in any year, the federal government could reduce the dollar-value multipliers for the following year by an amount that would be sufficient to recover the excess.

As a fourth major change in physician reimbursement, we recommend that Medicare require physicians to accept assignment — that is, accept Medicare's fee as payment in full (less any coinsurance and deductibles) — for all beneficiaries. Neither patients nor physicians should be eligible to receive Medicare payments for services rendered by physicians who refuse assignment. Failing to adopt "mandatory assignment" would undermine the effectiveness of a fee schedule based on relative values, since physicians who were dissatisfied with the fees paid by Medicare could charge patients whatever the Medicare fee schedule denied them. Unfortunately, immediate introduction of mandatory assignment could adversely affect access to care under Medicare, since physicians in certain areas might simply refuse to treat Medicare beneficiaries. Thus, this change in payment policy should be implemented gradually over 5 to 10 years, and it should start with mandatory assignment for all physicians' services to hospitalized patients.

Reforms in Payment of Hospitals

Medicare's current prospective payment system, a system of regulated prices that is based on diagnosis-related groups, is almost certainly an improvement over the cost-based approach to reimbursement that preceded it. Although the implementation of the prospective payment system does not deserve all the credit for recent declines in the rate of increase in hospital costs, it has contributed to growing cost consciousness among the nation's hospitals.

Nevertheless, the current prospective payment system has a number of flaws. First, it controls the amount paid for a hospital admission, but not the number of patients a hospital can admit. Since hospitals can thus boost revenues by increasing admissions of Medicare beneficiaries, the prospective payment system may not be effective in controlling costs in the long run.[18]

Second, Medicare's current prospective payment system may promote discrimination against certain groups of patients. Because that system controls only Medicare prices, it may make the elderly less desirable patients than privately insured persons, thus leading to a tendency to discharge older persons "sicker and quicker."[19] The prospective payment system also encourages hospitals to favor admission of Medicare patients who are in certain diagnostic groups and who are less severely ill. Uninsured patients also suffer under this system, since it is increasingly difficult to cross-subsidize their care from hidden surpluses that are built into Medicare charges and other fees.

We think that better prospective payment systems can be designed. We propose one here that should be considered if the flaws in the current prospective payment system create pressure for major reform. We recommend a system of prospectively set target budgets for hospitals that includes safeguards against discrimination against Medicare beneficiaries and uninsured patients. The fundamentals of this approach are as follows.

Each year, the federal government should set a target budget for hospital payments for each state. The states should then be empowered to devise ways to keep Medicare hospital costs within that target, or they should be required to make up the difference from their own resources. To achieve this goal, the states should have wide discretion in determining how hospitals within their boundaries will be paid for providing services to Medicare beneficiaries.

In designing payment systems, however, the states should meet certain federal requirements. All payers within their jurisdiction should use the same method for paying for hospital care, and the rates for different payers should reflect the costs of treating such patients — not the market power or the negotiating skill of the payers. The states and each hospital should negotiate a limit on the hospital's total revenues from all sources for the next year. If those target budgets are exceeded, the hospitals involved should be paid at a reduced rate for the rest of the year. The states should also be required to establish systems to cover the costs of caring for uninsured patients. Medicare should contribute to such uncompensated care schemes.

Experience in this country and abroad (Massachusetts and Canada, for example) has demonstrated that such a system is workable and that it can constrain the rise in hospital costs. Because this system limits hospital budgets instead of Medicare prices, it promises to be a better method than the prospective payment system for reducing the rate of growth in hospital costs over the long term. By limiting increases in hospital expenditures for both private and public patients, the system would use Medicare's leverage in the health care system to limit the growth in all health care costs, not just Medicare expenditures. In addition, because it would create an all-payers system, the plan would ensure that Medicare patients were treated as fairly as other consumers of hospital expenditures. Finally, the proposed plan would provide federal leadership in designing solutions to the growing problem of providing uninsured patients with access to hospital care.

Reforms Related to Prepaid Health Care

The virtues of prepaying for health care, especially in HMOs, have been widely discussed.[20,21] Sixty years of experience and research have documented the ability of HMOs to deliver high-quality care at costs that are lower than those in the fee-for-service system. These organizations also expand the options available to consumers of health care, thereby creating pressures for innovation and enabling patients to find plans that cover services that best meet their needs.

Nevertheless, since most of our experience with HMOs involves working populations rather than retirees, some caution is indicated in applying that experience to Medicare beneficiaries. The very high costs of caring for some elderly patients may encourage prepaid health care organizations to enroll healthy Medicare beneficiaries selectively, thereby channeling costly patients back into the fee-for-service system. If HMOs are paid the average cost of treating a Medicare beneficiary in the traditional system but they enroll only beneficiaries who are healthier than average, overall Medicare expenses may increase. Also, HMOs have not yet had to provide as much in the way of long-term care as Medicare patients need. The ability and willingness of prepaid health care organizations to provide such care remains to be tested.

Nevertheless, the track record of HMOs is long and strong enough to justify encouraging increased enrollment of Medicare beneficiaries in them. The Medicare amendments of 1983 went a long way in this direction by reimbursing HMOs at 95 percent of the age- and sex-adjusted average rate of Medicare spending in the communities where they are located. To encourage additional enrollment, Medicare should allow HMOs to recruit up to 75 percent of their members from the Medicare population. (The limit is now 50 percent.) This would permit specialization in the health needs of the elderly, without taking that group of patients completely out of the mainstream of care.

If the Medicare program and its beneficiaries are to benefit fully from the option to choose among HMOs, it is essential to promote informed decisions and to discourage selective enrollment of healthy older persons. Medicare should provide its beneficiaries with easily understandable information about the benefit packages and costs of all participating HMOs. To counteract incentives to stint on costlier services, such as those involved in the treatment of chronic illnesses, Medicare should monitor the performance of the HMOs. Currently, professional review organizations oversee the quality of hospital care to counteract similar incentives under the prospective payment system. They should do the same for HMOs.

CONCLUSION

Predicting the costs of all these suggested reforms in the Medicare program — some of which would not be implemented for 5 to 10 years — is difficult and hazardous. If we exclude additional long-term care benefits, we estimate that the financial impact of our proposals on Medicare expenditures in the year 2000 could range from a net saving to a net cost of approximately $3 billion (1985 dollars), depending on the assumptions used.[1] Coverage for long-term and nursing-home care would increase Medicare's spending by about $50 billion annually, although $35 billion of that amount would substitute for costs that would have been paid by Medicaid or by elderly persons and their families.

It is imperative to consider these costs in assessing the merits of our package of proposals. Yet, it is just as essential to consider other factors that have received less attention in the current fiscal and political climate. For example, given the current drift of Medicare policy, what kind of protection against the financial costs of illness will elderly persons have in the year 2000? What kind of access will they have to services? How will we care for the growing numbers of elderly persons who can no longer live alone?

These questions deserve study now, if only because current changes in policy should be informed by long-range considerations. In 1965, the political process produced a Medicare program that, for all its current failings, represented a triumph of humane public policy. It is now time to correct those failings so that the program can meet the challenges of the next 20 years.

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MEDICARE AND ISSUES OF ADMINISTRATIVE DESIGN

Theodore R. Marmor

I. Introduction

This paper is not about what Medicare should cover, whom it should enroll, how it should be paid for, nor what its aims should be in connection with an American welfare state. Rather, it is concerned with how such a program should be managed and who should have authority over what kind of question.

A. The original understanding: programmatic innovation, administrative conservatism.

Medicare originated as a federal program mediated by the non-governmental insurance industry.*[1] Tacit bargaining with providers won support for a program which many--especially doctors--had strongly resisted: namely, universal, compulsory hospital insurance for social security beneficiaries over 65, surprisingly topped up by a Federal Employees-style Part B that covered physician's services on the model of an Aetna high-option plan, complete with deductibles, co-insurance, choice of extra billing, and administration by a fiscal intermediary.

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*Medicaid was tacked on through the conventional federal-state apparatus of public assistance: management by the states with the federal government sharing cost and having limited control over whether state priorities remain consistent with the broad Medicaid statute.

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This administrative structure reflects the strong provider resistance at the time of Medicare's enactment. Medicare's designers and first administrators sought consensus with providers in order to ensure smooth and timely implementation. However, this led to a structure of benefits and payment that were to exert inflationary pressure and make governmental control of subsequent cost increases difficult. Despite detailed regulations, the vagueness of definitions ("reasonable costs and customary charges") proved to be a significant loophole, allowing energetic "gaming" strategies on the part of providers. In addition, unusual allowances for depreciation and capital costs contributed a built-in inflationary impetus. The use of private insurance companies as administrators preserved physician autonomy and left weak controls on reimbursement. Intermediaries were to determine the reasonableness of costs under Part A and charges under Part B and to pay them. This produced a biased arbitrariness in calculations that continues today.

Since the early objectives of Medicare administrators were to promote the program's acceptability and to see Medicare smoothly implemented, they were not organizationally disposed to the confrontations necessary to restrain cost increases. Although Medicare's designers were aware early on of the need to control costs, ultimately cost was limited by how willing lawmakers were to raise taxes[2].

Medicare's vulnerability to the vicissitudes of the health industry exposed administrators to tensions that were foreign to the Social Security way of managing things. Medicare, unlike its parent agency, was subject to varying demand--there were no simple formulas for benefit computation. In addition, technology helped to make medical care more and more expensive over time. Furthermore, Social Security's administrators prided themselves on their history of successful implementation in social insurance. This created an organizational attitude which led administrators towards conciliation with the industry. Vigorous cost control threatened this of cooperative disposition. In fact, fears of displeasing providers prevented or frustrated stringent attempts at cost control. Yet, despite these fundamental barriers to efficient management and equitableness, the conviction remained that there were possibilities of adjustment once the initial implementation was effective.

B. Two decades of tinkering: incremental change made without apparent choice and substantial choice posed without fundamental change.

Medicare's first twenty years saw numerous reforms in federal health care programs. Yet, Medicare itself has experienced no administrative restructuring comparable in its comprehensiveness to the enduring changes made in Social Security in 1939, less than five years after its original enactment. Struggles over national health insurance and hospital cost control left Medicare's administrative structure largely intact. The need for Medicare reform was partly obscured by preoccupation with broader changes, aided as well by entrenched attitudes and political fears.

The cost explosion that followed the passage of Medicare occasioned a search for causes. A 1970 Senate Finance Committee Report identified the range of inflationary pressures, which included the generous depreciation allowances for hospitals and allowances for capital costs, and the weak efforts by fiscal intermediaries who, given their close ties to providers, had few incentives to control costs. In 1972 amendments to Medicare were passed, but they consisted of minor policy adjustments and some reimbursement experimentation with no suggestions of altering the basic administrative design, that is, strengthening federal capacities for control or qualifying the discretion of intermediaries. During this period, Medicare administrators were in a difficult position--they had to respond both to providers and beneficiaries, as dictated by legislation, and try to meet the concerns of politicians worried about costs.

Although partly stimulated by critiques of Medicare, the early seventies' innovations in governmental programs focussed on reforming American medicine, not Medicare. From 1970 to 1974 national health insurance (NHI) was prominently on the political agenda and the legislation enacted was part of a larger design for an eventual national health insurance program: PSROs, HSA's, medical school expansion, the support of HMO's. There were attempts to implement utilization review and to limit capital expenditures. But utilization review was dominated by providers and hospitals found ways to avoid most constraints on their capital costs. Originating outside of Medicare's administrative staff (and in fact viewed with hostility by some Medicare administrators), the new programs relied on state and local initiatives and were intended to circumvent the "protectiveness and particularism" of program specialists. These measures of the early seventies were part of a broader scheme that ultimately failed to materialize. When proposals for national health insurance failed to pass Congress, these new programs became incomplete alternatives to systematic reform and, because of their contribution to the diffusion of federal political power, deflected centralized reform.[3] Most importantly, these reforms were almost destined to fail as Medicare cost control because they left the basic inflationary structure--retrospective payment, pluralistic financing, and intermediary administration--intact.

As the prospects for national health insurance faded, the impetus shifted from new programs consistent with NHI to a renewed, stronger emphasis on overall cost control, that was similarly broad in approach. The resulting stalemate over controlling health costs in the late seventies did not weaken the government's mandate. The failed attempts of the Carter administration to pass hospital cost control legislation did put the health care industry on the defensive[4]. And with the reorganization that placed both Medicare and Medicaid under the Health Care Financing Administration (HCFA), an organizational change occurred that partly released Medicare from Social Security's managerial ethos and bureaucratic style. Medicare became "one element in the broader universe of federal health care financing programs."[5] Medicare administrators became more concerned with health policy than with social insurance. This ultimately engendered payment reform from within Medicare which was designed to operate under its administrative strcuture.

Medicare's release from Social Security prompted hopeful optimism in the late 1970s. But, it obscured the program's need for administrative reform that recognized the true sources of medical inflation, the erosion of benefits, and the confusion experienced by beneficiaries. Unreconstructed, Medicare continued to be subject to large annual increases in expenditures as the decade closed. Medicare continued to be seen as social insurance and, because of popular support, escaped draconian budget cuts. By contrast Medicaid experienced not only budget cuts but also far more accusations of abuse. This was an apparent confirmation of the longstanding conviction that programs for poor people were in practice poor programs. However, Medicaid's design left it vulnerable to much the same kind of industry manipulation as Medicare.[6] States honored the Medicaid mission haphazardly. Medicaid's fate in each state varied according to its bases of political support, its varying potentials for mismanagement, its financing arrangements, and its loci of government responsibility.

In their attitudes towards dealing with providers, Medicare's administrators moved during the seventies from consensus building to bargaining with providers over the terms of reimbursement to, finally, strengthening administrative resolve at the federal level.[7] Recent changes within Medicare itself have mirrored this new focus on possibilities for program reform. Since 1977, the battle has been in part over information. The implementation of a new payment mechanism using diagnosis-related groups (DRGs) culminates a recent struggle over standardization. The possibilities for controland meaningful negotiation have increased with HCFA's enhanced ability to analyze comparative hospital costs. Prospective payment has put providers on the defensive. Medicare's role is no longer simply to aggregate, review and reimburse costs. Claims processing has been superseded by rate setting. From a symbolic building block for national health insurance Medicare has developed into a publicly funded program subject to norms of managerial efficiency and accountability for its costs. Curiously, however, except in those states where Medicare's administration was waived to state agencies, this has occurred within the same 1965 administrative structure.

Medicare's administrative arrangements still mirror the private insurance practices that evolved over the fifty years prior to 1965. Incorporating Blue Cross's mode of paying hospitals, Medicare simply froze into place and intensified a pre-existing inflationary structure. Components (cost definitions) of that structure, which arose out of a pitched battle between government and providers, have been supplanted by the recent use of DRGs, but it remains in its basic outline in an environment where the government role is one of several important issues.

The health industry grew at an astonishing rate in the seventies and by the end of the decade there was substantial change in the constellation of political actors. The vast public and private outlays on health care, the entrance of proprietary corporations, the imitative behavior of voluntary hospitals, the growth of HMOs and the relentless management tinkering within health institutions prompted a new debate. All of a sudden, doctors and hospitals were being threatened by corporate enterprise.

The effect on the political environment is not immediately clear. But what is apparent is that the forces at work in medical care render invalid the 1960s terms of debate and radically differ from the environment which contributed to Medicare's original adminstrative structuring. Market reform proposals, corporate enterprise in health, physician autonomy, and costs are on the agenda now, not "socialized medicine." The federal government is a major payer for care and is expected to manage its expenditures.

None of the reforms made in Medicare have attacked the threatening inflationary dynamic at its core. Although DRGs have shifted the emphasis from costs to prices, they do not necesssarily offer a solution to cost inflation. They have, for the time being, given the federal government considerably greater information, discretion, and control of its costs. And they strengtnen the trend to greater use of extra-hospital resources. They also strengthen the hands of hospital administrators versus physicians and create the basis for tougher bargaining between government officials and hospitals. Whether a redesigned Medicare suits the demands of a new set of interests or subordinates those demands to its own historical objectives remains to be seen.

II. The Options Under Siege: Medicare in the 1980s

A. The area of agreement.

Most would concur that the initial operating premise of the Medicare program--expand insurance coverage, but leave the vendors to set within broad limits their prices (or costs)--was wrong. The administrative corollary of that policy--to use fiscal intermediaries as a "buffer" between government and providers--has been criticized as well.[8] This is defective public policy and design even if originally required by the conditions of enactment in 1965. Whatever the necessities of 1965, however, it has been wrong to let that continue for two decades. Explicable, perhaps, but lamentable, even if broader reform seemed possible in the 1970s.

The need to explore new options now, however, does not mean damning the original deal. The original dealers assumed there would be adjustments, as there were in the late 1930s for social security cash programs.

Medicare is now on the political agenda, prompted not so much by public administration theory but by the American budget deficit. Other chapters have reviewed the startling growth of Medicare over the past five years and the erosion of protection because of medical inflation and increases in premiums, co-payments, and uncovered physician fees. Whatever the wishes of the Medicare godfathers--and we suspect they would have arrived incrementally at both beneficiary expansion and management reform--as budget pressures force programmatic review, administrative design must also be examined.

B. The Problem

The basic business of administering Medicare consists of setting rates and negotiating adjustments over time, establishing benefits, determining eligibility, making payments, enforcing regulations (concerning cost, access, and quality), and handling the concerns of beneficiaries. Adminstrative policy concerns not only what levels of government will actually perform these tasks, but also where authority over these functions will rest, independently of who performs them. As experience has shown, although financing and overall authority for a program may be federal, assigning payment and negotiation to private intermediaries or delegating certain authority to states may nonetheless undermine federal government authority. Therefore, the key administrative questions are which functions belong in which organizations, and how does this placement enhance or deter meeting the broad objectives of Medicare?

If we assume that Medicare financing remains federal, the program's administration will use one of the following three actors or a combination of them: (1) federal sub-national authorities--HHS regions; (2) states, who can administer federal laws or work under contract* (Also federal law can provide negative or positive incentives for state participation, or federal and state laws regulating the same conduct can be independently enacted and enforced.)[9]; and (3) non-governmental agents, as is the case under the federal employees' health insurance program, and, in many respects, the current Medicare program. This set also includes voucher proposals and HMO-oriented reform.

Our discussion will concentrate on two options as yet undeveloped for Medicare: federal authority and administrative concentration (with subordinate federal units at the local or regional level); and federal authority and state administration. In assessing the second option, the lessons of state administration of Medicaid are helpful. Also in the second option the federal government may allocate some authority as well as administration to the states. We make use of four criteria for administrative redesign of Medicare: (1) Does the administrative design affect the equal treatment of beneficiaries? ; (2) Does it encourage or impede control of overall costs?; (3) Does it increase or decrease the complexity of the program, as experienced by beneficiaries?; and (4) What level of political support does it command?

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*Two examples of federal/state cooperation: disability insurance, using federal funds, guidelines,and federal payroll for state employees under contract; and state all payer hospital rate- or budget-setting experiments, where a state agency runs the show with federal cooperation and support.

III. Issues of Administrative Design

A. Equal Treatment

In the context of a program aimed at all Americans over 65, one administrative question is to what extent the macro-design of Medicare's management contributes to equal treatment in different regions and political jurisdictions. At one extreme, location may be irrelevant--for example, in determining the proportion of charges paid for a given illness. Yet, citizens' treatment under Medicare may also vary considerably, not only with the availability of doctors, hospitals, and pharmacies, or with the different outcomes possible, for example, under a voucher system, but with the administrative predilections or, simply, capacities of the local authorities.

The case for direct federal responsibility for Medicare administration is an old and considerable one. Its main premise is that advancing the equal treatment of citizens requires both national standards (not necessarily identical terms) and incentives to enforce them. Where variations in treatment are warranted, there is a case for considerable decentralization of authority. Where uniformity of treatment is wanted, the appropriate design is concentrated authority and administrative deconcentration* of operating units. Quality standards for hospital buildings might exemplify the first; disability payments for veterans might well illustrate the second.[10]

Locating authority and responsibility for administration at the state level has, as in the case of Medicaid, violated the principle of equal treatment of equals. Although the variation among states in Medicaid coverage has lessened over time, state programs continue to vary considerably in per capita expenditures and extent of coverage.[11]

In addition, the greater vulnerability of state governments to particular organized interests, suggested by the treatment of nursing home operators by some states[12], casts doubt on equally satisfactory state responsiveness to disadvantaged portions of the population.

Federal administration is thought supportive of national uniformity.[19] Where state administrative personnel are clearly superior, there might be a case for their use on this ground alone. But other things being equal, the case for uniform administration lies with the federal government. Indeed, when

> ... states cannot or will not meet national goals,and when Congress has determined that achievement of these goals is critical, equity and equality dictate that national government should take responsibility for implementation. The Voting Rights Act of 1965 provides perhaps the most dramatic example of these circumstances:distrust of states' commitment to minorities' rights led to reliance on federal marshals to enforce federal law."[20]

Whether such dramatic intransigence applies to health care is not apparent--there are economic incentives for states to conform. However, continued fears of weak state administrative capacity, as with implementation of management and monitoring systems and lags in processing, coupled with federal political unwillingness to punish states, argue against state administration of federal social programs, or at least against allowing states broad latitude in the administration of federal mandates.

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*Centralization implies greater autonomy for subnational actors, be they state or federal; deconcentration simply disperses the location of administrative units, while devolving little actual authority.

Proposals for a voucher system would leave considerable discretion in the hands of citizens and allow for the operation of the market in meeting preferences. However, these proposals raise serious questions of equity and administrative control. Consumers are often without the information or other resources to exercise that discretion in their own health interests. Requisite definitions of high risk persons entailed by this design are difficult and there remains the possibility of a two-tier structure for high and low risk patients.

Furthermore, a voucher system might increase program complexity, thus posing problems of adequate oversight of industry practices and tempting insurers to exclude high risk categories. Offering choice between public and private programs and opening public programs to higher income groups are possible ways of overcoming problems with voucher plans. However, vouchers also pose problems for cost control. And, as Feder observes, "if the market system allows costs to rise, inequality...is likely to result."[13]

The original aim and continuing aspiration for Medicare is relatively uniform protection of older Americans, regardless of where they live. The questions of what benefits should be covered, what co-payments should be permitted, what confusion should be reduced are all matters in which national citizenship dictates the standard of equal treatment. The corollary, in principle, is that one agency of the federal government should have authority for setting the terms (i.e. eligibility, minimum benefits) of, a program with national aims. Medicare now operates under this broad design. Its particular sub-national agents happen to be fiscal intermediaries outside government. But, the arguments for federal authority do not entail a particular form of subnational administrative design. It is perfectly possible to imagine federal administrators of federal programs, state agents of the federal government, or non-governmental agents as well.

B. Control of Costs

The relation between administrative design and the control of medical costs is a complicated one. Two principles of management apply here. In general, the fusion of responsibility for finance and broad administrative oversight is preferred by students of management. The more those who finance a program are responsible for its operation and basic guidelines, the more likely the costs and benefits of major decisions bearing on outcomes and operational choices are weighed together. At the consumer level, this fusion is complete for most choices in the marketplace (buyer, payer, beneficiary are all the same). For government programs, the notion that one level of government should pay and another administer--although most domestic federal programs operate in this fashion--is open to serious objection. Accountability requires that those who pay be at the very least in a position to control their outlays.

The second principle is simple as well. The larger the share of outlays a particular unit of government finances, the greater that unit's incentive to control overall costs rather than to shift them. The interstate highway system has a built-in incentive to expansion because of its federal/state financing arrangements. The formal arrangement is 90/10 federal/state sharing of cost. Since the benefits are local and the costs are largely federal, local politicians receive most of the credit for outlays other units of government mostly finance. Since the problem of Medicare now concerns program outlays, federal concentration of authority might well be considered an essential precondition for reasonable cost control. Any delegation or decentralization of authority to non-federal agents would not occur unless that agent shared in financing.

This does not mean, however, administrative control over actual payment, but it does mean responsibility for outlays. There are other ways to produce a balance between costs and benefits--for example, per capita block grants which have peripheral administrators responsible for all the marginal costs of a block grant. Rather than the current open-ended federal matching of state Medicaid expenditures, the utility of block grants, such as those used in Canada[14], would shift some responsibility for cost control to the states. Alternatively, closed-ended matching, where states share authority might stimulate efficiency and prevent underexpenditure.

The Medicaid experience of the last decade provides at least two broad lessons: states have limited ability to control some kinds of medical costs[15] and the state implementation of managerial controls often has been disappointing.* Many failures, however, were not due to state incapacity or unwillingness to act; some factors such as the effect of higher Medicare fees[16] are beyond state control. Also, Medicaid constitutes a small portion of overall health expenditures in each state--this is a disincentive to firm controls on Medicaid since providers might otherwise deny or reduce service to beneficiaries. Regulation of all hospital payers is one way to avoid these problems. The administration of Medicare and Medicaid by one state agency, operating under federal guidelines, might also reduce the importance of such problems.

As noted earlier, Medicare used fiscal intermediaries as a partial political buffer to soften the impact of the original legislation. As the environment changed, a new relationship between government and providers developed, and as increasing costs assumed greater importance, the arguments for using private sector processors have emphasized efficiency rather than appeals to tradition. Economic performance has come to mean more than traditional loyalty. Despite this different appeal, the tendency of providers to play off payers against each other as well as the inclination of commercial payers to shift overhead costs to public programs have drawn into question the role of private actors in public health programs. In the absence of reimbursement controls on all payers, the use of private firms must be examined. However, this must also be balanced against the federal government's uncertain ability to provide efficient processing of health insurance claims on the scale that Medicare requires.[17] And there is, of course, a potential compromise in which private firms do processing under tighter contractual terms.

If the federal government pays and the states administer programs autonomously, the clear incentive is to shift cost to the nation and concentrate expenditures locally. Where spending more is doing good, this is almost always the case. The opposite prevails where the federal government requires the location of public nuisances and the states are responsible for siting such "bads." The difference between pork barrel and "bile barrel" politics is immense in practice, but their logical features are common.[18] In one case, costs are shifted away from

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*as in the case of the Medicaid Management Information System.

beneficiaries; in the other, burdens are shifted away from those who benefit. In the first instance, more outlays are the predicted result; in the second, massive local resistance is forecast. Both cases support the argument for concentration of responsibility for both benefits and burdens at one level, be it state or federal.

On the other hand, there are forms of administrative deconcentration that are compatible with the principle of clear responsibility. Consider the case of giving states per capita grants for the administration of Medicare and Medicaid under clear federal guidelines regarding eligibility, coverage, co-payment, and administrative publicity. The clearer the guidelines and the simpler the program's design, the easier it is to hold states to account as agents of the federal government. (This chain of reasoning is highly conditional. It follows only if guidelines are measurable and sanctions are enforceable and if required programs are in place.) This does not eradicate the fiscal incentives to shift costs, but strengthens the political capacity to resist such shifting. In the past, Medicare has been hesitant to punish either states or private processors.[21] Simplified national standards (especially on eligibility) would still leave administrative tasks to the states in regulation, payment and quality assurance. The implementation of controls for all payers would enhance state influence in Medicare administration.

C. Complexity

Clearly any simplification of the basic program should address the confusion facing Medicare patients in local settings. Although simplification is designed for beneficiaries, by presenting local agencies with clearly defined and comprehensive mandates for control, their tasks will be eased. Medicare beneficiaries face a complicated array of options for coinsurance. In appealing denied claims they are presented with hard-to- decipher letters, inadequate means to obtain evidence for their claims, and an appeals process that is not as fully developed as that for, say, disability insurance[22], or social security in general. These conditions stem in part from the use of private carriers as intermediaries for Medicare.[23] No clear hierarchical line exists between HCFA and its intermediaries.

The terms of hearing and appeal under Medicare Part B clearly reflect the insulating effect of the private intermediaries, whose historical function has been to mediate the interests of providers and physicians. The lack of access to information and the arbitrary means for decision making betray a fundamental bias against the beneficiary.

Ideally an administrative reorganization would set in place clear lines of responsibility and fully developed procedures for review and appeal. These in themselves do not guarantee fairness or non-arbitrary behavior, but do represent a vastly better situation than one where beneficiaries are at a loss to even begin to appeal claim denials. Furthermore a system where claim denials are borne by beneficiaries rather than providers shows some of the inherent problems of using deductibles. A patient, faced with a bill summary, is confused by percentage deductibles for Part B which when redress is sought, are variously computed by the intermediaries at different stages of appeal. To further compound this problem, purveyors of Medigap plans apply their own deductible amounts to Medicare deductibles. The confusion results not simply from the policy of having deductibles, but from the absence of administrative mechanisms for properly clearing such disputes and for assessing the effects of such deductibles.

The proposals for reducing complexity of Medicare are within the federal purview. Combining Parts A and B and creating a uniform structure of cost-sharing and payment terms will be result of federal redesign. DRGs and the recently proposed physician fee schedules are examples of national efforts which locate much of the reform initiative with the Health Care Financing Administration. How these proposals affect the states and/or others' roles should be assessed in terms of how they easily they can be administered.

In terms of centralized national administration, the combination of A and B and the enhanced controls on each pose problems for a program administered from Washington, and charged with keeping track of millions of physicians and thousands of hospitals. Replacing the old insurance structure with a regulatory structure argues for lodging greater responsibility for detailed administration with state and other actors.

Responsibility for reducing complexity rests only with the federal government. Placing this responsibility in other hands might result in substantial state-to state variation or a bewildering array of options facing the beneficiary. Any administrative design that is concerned only with ease of administration, or with meeting the concerns of providers, will not address the specific problems of complexity that are pressing for the beneficiary who cannot puzzle out the various deductions and insurance options currently present in Medicare.

D. Political Support

Finally, political support is a criterion central to the appraisal of administrative options under Medicare. The question of which group--providers, beneficiaries, or payers--supports particular administrative designs looms large in the evaluations of congressional decision makers. The use of fiscal intermediaries was of course influenced by the desire to see Medicare smoothly implemented. Now, when implementation and program legitimacy are assumed, support and opposition will emerge around entirely different issues from a new juxtaposition of interests and differently framed questions of public policy.

The political support for administrative change is difficult to assess. The reasons behind such support may be realistic or mythical, based on likely substantive effects or ideological presuppositions, grand or trivial. But one ignores such considerations at the peril of irrelevance.

No serious student of Medicare can ignore the degree to which a few states have energetically taken on the regulation of the medical industry. If states have strong regulatory programs already in place, that argues against the duplication of federal efforts. And, since in American politics much regulatory authority over this industry is at the state level, the use of state administration for this purpose has inertial support. Moreover, at a time when the popular regard for federal administrative capacity is low, there are further grounds to believe that such decentralization is less controversial than at other times. And, finally, we do not have a tradition of aggressive use of regional federal offices to oversee the Medicare program.

On the other hand, early problems with the administration of Supplemental Security Income, although remediable, raised in the early 1970s the spectre of maintaining sensible control of field officials who accomodate geographic variation and the complexities of means-tested programs. State administration might prove more responsive, without the greater uniformity we expected from deconcentrated federal authority. Unlike Social Security, Medicare payments have flowed through insurance intermediaries. Substituting state regulation would make a great difference to providers, but would hardly be noticed by Medicare's elderly clients unless program benefits and administrative practices were changed as well.

In the interest of accountability, we do not want numerous actors, but we may have to have them. Giving more responsibility to the states without clear guidelines is an option that flies in the face of our experience. In the turbulence, we have reason to worry about cross-state actors. The clear case is for no break in the line of responsibility. This will not be accomplished by simply assuming that federal financing and overall authority means adherence to federal goals, or that state financing and administration will avoid the problems of federal administration.

FOOTNOTES

1. Theodore. R. Marmor,*The Politics of Medicare* (New York: Aldine, 1975), Chapter 4.

2. Lawrence D. Brown, "Technocratic Corporatism and Administrative Change," in *Journal of Health Policy, Politics and Law*, Fall 1985, forthcoming. Judith Feder, *Medicare: The Politics of Federal Hospital Insurance*, (Lexington, Mass.; Lexington Books 1977). pp.2-3.

3. Brown, p. 23.

4. Brown.

5. Brown.

6. Judith Feder and John Holahan, "Administrative Choices", Chapter 1 in Judith Feder, John Holahan, and Theodore Marmor, eds., *National Health Insurance* (Washington, D.C.: The Urban Institute, 1980), p. 55.

7. Brown.

8. Feder and Holahan, pp.33-5.

9. J. L. Mashaw and S. Rose Ackerman, "Federalism and Regulation" in Eads and Fix, eds., *Reagan's Regulatory Strategy III* (Washington, D.C.: The Urban Institute, 1984).

10. Feder and Holahan, pp. 28-31.

11. Feder and Holahan, pp. 46-47.

12. Feder and Holahan, pp. 55.

13. Feder, p. 69.

14. Theodore R. Marmor, Wayne L. Hoffman, and Thomas C. Heagy, "National Health Insurance: Some Lessons from the Canadian Experience" in Theodore R. Marmor *Political Analysis and American Medical Care* (Cambridge: Cambridge University Press, 1983).

15. Feder and Holahan, p.52.

16. Feder and Holahan, p. 53.

17. Feder and Holahan, pp.33-35.

18. John J. Pitney, Jr., "Bile Barrel Politics: Siting Unwanted Facilities" in Journal of Policy Analysis and Management, Spring 1984, pp.446-448.

19. Feder and Holahan, pp. 23ff.

20. Feder and Holahan, p. 27.

21. Feder and Holahan, p. 36.

22. Jerry Mashaw, Bureaucratic Justice, (New Haven, Yale U. Press, 1983)

23. David v. Heckler, 91 Federal Supplement 1033.

Chairman Stark. Ted, thank you. As usual, your ideas are stimulating. I suspect you have raised some issues that the committee would like to question you on further.

Mr. Gradison.

Mr. Gradison. Mr. Chairman, basically I am not sure the witness is talking about the same program that we are looking into today. I think he has indulged in some substantial revision and in his interpretation of the last 5 years.

Reading his statement and listening to him, one would think that this is a highly partisan matter, that these changes have somehow been hoisted upon the American people over the last 5 years without the support of Members of both parties in the Congress. Indeed, that is borne out by a careful reading of the testimony. That is not the case.

The administration has proposed a number of changes. They have been approved by the Congress. They have been approved by a Congress overwhelmingly controlled by the party other than the President's, and by a Senate narrowly controlled by the President's party.

Both parties have had in mind, in spite of what the witness says, a desire to lower the inflation rate. They have had a substantial degree of success in doing so.

I think basically what we have been trying to do here, and should continue to try to do, since the Federal Government has not exactly distinguished itself over the years as a leader in bringing about a change in medical economics, is to learn from what is happening in the private sector. I do not think we are doing anything much more or less when we look at specific ideas. I think many of them are actually being borrowed from things that appear to be working elsewhere, but Washington is often the last to know and the last to apply these ideas.

Virtually every point you have made, Professor Marmor, could have been made 5 years ago, about the changes that have been made during the last 5 years. I don't want to say that nobody has been harmed by the changes over the last 5 years. I think it is fair to say that the system has worked out awfully well over the last 5 years, that many of the fears that you have expressed looking to the next 5 haven't been realized by the changes made over the last 5 years.

Mr. Marmor. Could I answer that?

Mr. Gradison. You bet.

Mr. Marmor. I think you have been quite general in your statements about which changes produce what effects. Most of the effects I suspect you would regard as desirable are associated with the responses to prospective payment within Medicare. That is the largest change that has affected the hospital——

Mr. Gradison. That is correct.

Mr. Marmor. My concern, frankly, is about proposals for increased cost sharing, most of which you have actually resisted in the Congress. My concern is also about the efforts to change eligibility, most of which you have resisted, but not all of them. The proposal, for example, of making Medicare a secondary payer which shifts costs to the private sector, is not one you have addressed.

I believe, and I think you are right, that the major thing already accomplished was to transform the way hospitals are paid in America for Medicare patients. That has presented both opportunities and risks. But while I think I can say in fairness that not everything that has happened in the last 5 years either have you not supported nor have I supported, that one transformation certainly, I think, has been an improvement over the past.

That is an example of an opportunity—to change the way by which hospitals regard their costs. It has risks associated with its virtues. You know those as well as I do.

It is clearly the case that Medicare patients and other patients in other parts of the country have faced problems as they presented sicker diagnoses to hospitals. We have cases of dumped patients. We have cases of shifted patients. We have cases of people dying as they are moved about. I don't want to recite those. You know those are the risks when you change the incentives so dramatically with prospective payment.

I think we have a mixed picture on that score. My concern really was to link the administrative themes of the last 5 years, not the policies you have accepted—the themes of increasing patient cost sharing and reducing the costs of the Medicare program—to the proposals you have in front of you. Those themes are the same and these proposals illustrate those themes.

Mr. GRADISON. Basically I think you are assuming the willingness of people to pay taxes that I don't see among my constituents. I think that is really what it comes to.

The reason we have generally rejected in this subcommittee, on a bipartisan basis, increased payments by beneficiaries is we don't think they ought to pay any more. We have not supported increases in taxes for the same reason.

The logic of your argument is we should reduce cost sharing, not increase it. You are not saying leave it alone. If we reduce it, somebody has to pay the difference.

Mr. MARMOR. That is absolutely true. The relevant first question about reduced cost sharing is how one is going to finance that shift.

Mr. GRADISON. I believe you said you would finance it from increased premiums. Did I misunderstand you?

Mr. MARMOR. Not at all. You didn't misunderstand me one bit. It is indeed what I said. If you want to rationalize Medicare payments and to rationalize the program's benefit package, you could hold the elderly fiscally neutral by shifting the balance between premiums and cost sharing. When you say it is hard to raise taxes and, at the same time, suggest increased patient cost sharing, it is worth remembering that both are payments on behalf of Medicare. There are possibilities, in other words, for either raising the net medical payments by the elderly or other Americans or readjusting the financing package now as between premiums and cost sharing.

We could have a perfectly sensible discussion, independent of raising in the aggregate the amounts paid by the elderly, about what makes fiscal sense for the elderly to pay for medical care. I want to discuss this further and the broader question of whether we should be thinking about improving Medicare with respect, for example, to long term care, which simply could not conceivably be financed without raising revenues in a more direct way.

That is an exceedingly important matter. We could talk about a catastrophic plan that, at an aggregate cost of perhaps $500 million, protects us all from financial disaster. Some of the cuts proposed here seem to me so wrong-headed that it it would be worth spending $500 million to stop them. But a catastrophic plan, candidly, would involve expenditures at that level.

On the question of beneficiary cost sharing, that narrow point you have been mentioning, it is possible for us to have a discussion on the merits of it, independent of the points you raised.

Mr. GRADISON. I understand that. Let me come to what I think we ought to do and ask your reaction to it.

Let me focus for the moment on part B. A Federal subsidy of 75 percent of the benefits provided under part B doesn't make any sense for well-to-do elderly. Requiring low-income elderly to pay 25 percent of those costs doesn't make any sense to me either.

It seems to me you have to stop looking at the elderly as a single group and ask instead whether we shouldn't be making some distinctions among the elderly in terms of what we are asking the general taxpayer to subsidize.

We were working on a plan right here, which was bipartisan by the way, to try to vary the part B premium with the income of the beneficiary as a means not of socking it to the elderly as a group, but trying to reduce the cost burden on those least able to pay. We were trying to do it on a revenue neutral basis because of the difficulty of raising new revenues for this program from the outside.

What would your reaction be to a proposal in principle along those lines?

Mr. MARMOR. My reaction would have three parts to it, I guess. First, I should think you would not want to justify such an adjustment in the way in which we finance part B by referring to some mythical history of Medicare. Medicare's part B was added at the last moment. Nobody worked it through. So we want to reduce the amount of Medicare-bashing, it seems to me. That would be the first, but small, point.

Second, I share your concern about the financing of part B and its income distribution effects.

And third, I would, however, be exceedingly concerned about the way ones uses more progressive sources of revenue to finance the part B premium. And there are a number of possibilities.

For instance, you seem to be concerned that the amount of payment for part B vary with income, as I take it.

Mr. GRADISON. That would be one approach.

Mr. MARMOR. One approach. And there are two ways I can think of doing it. One way, for example, would be to express the premium as a percentage of monthly Social Security payments rather than a flat amount per month. That introduces a way of thinking about it that has nothing to do with invidious tests of means. It says that Social Security income and previous income are highly correlated. One would want a low percentage; you don't want to have 75 percent of part B paid for this way. That would be one idea. The other would be to use taxes on Social Security payments.

The important philosophical point I want to make is that the way one pays for part B—or part A—has to fuse two competing objectives: One is the objective of raising the money, the resources, in a way that's fair with respect to ability to pay, and second, to do so in a way that is compatible with our ideas about social insurance and the notion that Americans are treated equally under their social insurance programs once they're eligible for them.

So to balance those, I would be concerned about making sure that you wouldn't go off in one direction without considering the other. I wouldn't call, for example, for income-varying premiums. But I would suggest drawing from revenue sources that are more progressive in final impact than we've got now. One of them, as I suggested earlier, would be a small percentage of your Social Security income—in that sense, a Social Security-related levy—for health insurance. It's pretty close in practice.

Mr. GRADISON. Well, it would be a bargain for wealthy people to pay 100 percent of the premium, because they couldn't buy anything comparable in the market that would avoid selling costs and that would avoid and kind of a physical examination.

Mr. MARMOR. That's true, if you think about Medicare as completely analogous to private health insurance. But it's not. It's associated with a number of other features of American social policy that we ought to be cautious about jettisoning very quickly.

Mr. GRADISON. Well, the part B premium is optional. I mean, nobody has to pay for it.

Mr. MARMOR. Yes, but the reason it's optional is that part B was added at the last moment in 1965, and nobody intended to pay physicians under Medicare. Had we been thinking about it, it might well have been mandatory.

Mr. GRADISON. Well, we've had it 20 years, and we haven't changed it. Whatever the thinking was at the time, it's been reviewed and reviewed and reviewed and left unchanged.

Mr. MARMOR. Well, I don't know, frankly, that we've had so many searching reviews of the Medicare Program fundamentally. We've had lots of reviews of its costs and lots of worries about administrative difficulties. But, in fact, I cannot think of a time when, for example, the suggestion that part A and part B be fused was considered.

I myself think that would be a very wise idea. The idea of a separate physician's part and a separate hospital part made some sense in the mid-1960's, when we were used to Blue Cross/Blue Shield. But even Blue Cross/Blue Shield is fused now. Medicare is needlessly complex in the way it works itself out on the ground.

There are now two sets of cost-sharing arrangements. There are two sets of fiscal intermediaries. And indeed, I would say, Mr. Gradison, that a concern for the complexity of this program, as it's dealt with in fact by the elderly, should be given much higher salience than worrying about many of the things on which we spend 90 percent of our time. This program becomes a nightmare in the hands of the elderly, as we operate along these two separate streams.

It becomes such a complex operation that Wilbur Cohen, one of the authors of the bill 20 years ago, told me that he can't figure out his bills.

Mr. GRADISON. That's a powerful argument for capitation or a voucher, isn't it?

Mr. MARMOR. I think it is, Mr. Gradison. But I would also be unwise as an academic—and I'm mixing two roles here—as an academic, it would be wrong for me to tell you that, although it is a powerful argument for capitation, I believe one can reasonably predict that most Americans will be under capitated schemes by *x* date.

There are plenty of countervailing incentives for capitation that affect older and other Americans. We have had a decade, nearly 15 years now, of exaggerated claims about the number of people who are going to be in HMO's. I think it's something we want to encourage. I must add, too, as a side point, for the last 1½ years I've been involved with a study group on Medicare at Harvard University, and many of the issues you raise have come up.

Capitation is not something that I've studied every year for the last 20 years, but I'm much more familiar with it now than earlier. And it's fair to say that encouraging capitation is one of the new report's high points. The Harvard report is going to be out in another week or so—there will be a published document on it, which I would urge you and the committee to look at. It covers the full range of Medicare topics—from the role of beneficiary cost-sharing to eligibility issues to the questions of simplification of the administration to issues of long-term care and the difficulties such care raises.

So there is a much wider of set of topics that I'm not in a position today, because of the forthcoming publication, to go into in detail.

Mr. GRADISON. We will look forward to the report, and I'm delighted you're here. Thank you very much for taking time to come down. It's good to see you again.

Mr. JACOBS [presiding]. Mr. Daub?

Mr. DAUB. Thank you, Mr. Chairman.

Professor Marmor, are you in favor of national health care?

Mr. MARMOR. What does that mean, Mr. Daub?

Mr. DAUB. As provided by the Kennedy plan, for example, some years ago. Would you like to see us nationalize our health care program?

Mr. MARMOR. Well, those are——

Mr. DAUB. Have you ever advocated that we do that?

Mr. MARMOR. Sure. I suspect you knew the answer before you asked the question.

Mr. DAUB. I just want to lay some groundwork. How do you feel about it now?

Mr. MARMOR. How do I feel about it now?

Mr. DAUB. Yes.

Mr. MARMOR. I think that it's a waste of our time to talk about that issue when Medicare is under such fiscal seige. But if I had my druthers, which would be the candid answer, if I were in charge or in your shoes, and someone said, "Could we do better if we widened the participation of Americans in health insurance, mandated or through the Government directly," the answer would be yes. But I don't think it's a highly salient item for us today. I think it's a diversion, because what we're worried about is the preservation and better management of the programs that we've got at a time when the fiscal strain facing the Government doesn't make it likely that we're going to be moving in the area of massive, new infusions of public funds. And so, it seems to me to be beside the point.

Is that not right?

Mr. Daub. All right. I'm just listening now to your answers.

Do I take it that technically, in the end, as I read your testimony, because your rhetoric was certainly different and I had to read the conclusion, you would favor some means-tested approach to part B?

Mr. Marmor. Well, I have to make myself clear again. I don't know why——

Mr. Daub. I do want that to be clear.

Mr. Marmor. OK. I need to understand why it's so hard to make oneself clear about this matter. I am, in principle, fundamentally, philosophically, and practically opposed to tests of means as a way of rationalizing Medicare, and I hope that's clear.

That is, if you gave me that proposal, I would regard it as a step backward, a large step backward, a violation of promises made earlier. But beyond that, just wrong.

If you asked me, on the other hand—I'm trying to answer you particularly—if you asked me whether I think that the way we pay for Medicare ought to take into account progressive sources of taxation—that is, say, payments that increase as income rises—the answer is, yes, if you can do it without introducing any of the associations of means-testing in practice. And I gave Mr. Gradison an illustration of that.

I'll give you another illustration. You could, for example, increase the proportion of Social Security payments which are taxable, currently taxable to the IRS, and use that source of income to pay for part of the increased premium.

Mr. Daub. You mean the means test we applied to old age and survivors?

Mr. Marmor. Well, I can see I'm not making much headway with you, Mr. Daub. I think you're using that phrase as a red flag in front of 26 million elderly people, because they hate that word.

Mr. Daub. Well, then, by any other name.

Mr. Marmor. Well, if you put it that way, am I for increasing the proportion of income taken from upper-income groups to pay for social programs as against lower-income groups? The answer to that question is yes.

Mr. Daub. You've made yourself clearer.

Mr. Marmor. Aha.

Mr. Daub. Now the number of people on the elderly rolls today——

Mr. Marmor. I'm doing the best I can on that one.

Mr. Daub. We are delighted. We're getting there.

The number of people who are old today, as a proportion, is certainly than the number 20 years ago, correct, relative to when we started Medicare and Medicaid and these idea of history, as we were looking at them then, part B?

Mr. Marmor. Somewhat. Somewhat but not dramatically.

Mr. Daub. What does it look like for the next 20 years?

Mr. Marmor. Actually for the next 20 years, it's not going to change very much.

Mr. DAUB. What about the nature of the aging population, as a political scientist as opposed to a physician, do you see a change there, as this society ages—fewer births, fewer deaths?

Mr. MARMOR. Well, I think there are two things going on, and it's very important to be clear about them.

Over the next 20 years, as you know probably from your Social Security hearings, the general picture of the ratio of the elderly to the non-elderly does not transform itself. The issue for the future lies in the year 2020 and beyond. That's when the ratio of non-workers to workers shifts pretty fundamentally, as the young become old then.

So it's a distant problem. I don't want to minimize it, but it's not pressing on us today.

Mr. DAUB. How about going inside of those analyses, the elderly elderly, for example, and the proportion of increase in that category?

Mr. MARMOR. Fair point. There is no question that the most rapidly increasing proportion of the elderly is what one calls the "old old;" that is, those over 85. And any reasonable person of whatever partisan complexion who would deny that that presents serious difficulties for the society, not just for Medicare but for our entire society, would be fooling himself.

Mr. DAUB. Now as we analyze a point that did get my attention, which was this comment, for illustrative purposes, about the extension for 1 month——

Mr. MARMOR. Yes?

Mr. DAUB. Is it simply nothing more—postponement for 1 month—or nothing less than simply a grab at some money.

Mr. MARMOR. Well, cost-shifting is the way I want to characterize it. I want to distinguish between activities that reduce costs by refusing to pay for something that's worthless, activities which shift costs from A to B and don't change the social commitment or the social expenditure for health, sensible or not, and activities that improve productivity at a given level of cost.

Mr. DAUB. Thank you. I'm not headed there. I'm trying to get to another place.

If you took the idea of postponing or shifting or setting dates ahead—we looked at the 1983 amendments and we said, we're going to make the retirement age 67, and we're going to set it out to the year 2000 before we start it; we're going to phase that up on monthly increments over 24 years until we get to the year 2024, to take into account this movement of fewer 18-year-olds starting about 1992. And as that moves on the table, it helped us avoid a problem. We didn't have to take the people in the wagon and, at their expense in a way, reduce the benefits so much because of the higher cost to the people pulling the wagon, fewer of them, fewer workers, for about 20 years.

There is sort of a trough here. And we didn't have to raise their taxes as much, because it would be their benefit in the year 2040 that we're really talking about. So we said we're getting older as a society. We'll raise that retirement age. So my point, then, is why not raise the eligibility dates?

Mr. MARMOR. Mr. Daub, do you——

Mr. DAUB. I'm just asking for your answer on that.

Mr. Marmor. Yes; I hear you, and I'm going to answer that directly as you say.

As you put it, it makes some considerable sense. That is, if you are committed to the view that Medicare ought to be a program that goes to people who are formally retired under Social Security, and you believe—though it's false, factually—that most people over 65 are just retiring, or later on at 67, then it would make sense to fuse these two and slowly over time make a parallel between Medicare eligibility and Social Security eligibility.

Mr. Daub. Well, I don't want to do that, but I want to think about the demographics, though, and of the eligibility and cost over time.

Mr. Marmor. Or to put it another way: If you wanted to live up to the promise of 1965, you could say, "but there are many years after 67 now than there were in 1965, so in some way the promise would be maintained by increasing the age." You could justify it that way.

But the practical problem I want to introduce, Mr. Daub, is this. We know that most people are retiring before age 65, so that the gap between the end of employment and retirement under Social Security has grown as we've pushed up the Social Security age. That means Medicare eligibility is stuck somewhere in the middle. So there's not some easy, neat connection between those two. That was my substantive answer to you.

Now let me say why I brought up that case, because I don't want to mislead you. I brought up that case not because I couldn't engage in this discussion with you, as I think is evident from our exchange; it's that it strikes me as simply a convenient, telling example of a cost-shifting move that was picked primarily because it saves some dollars, not because it's coherently defended against a broad long-term scheme of the sort that you're suggesting.

Mr. Daub. All right.

Mr. Marmor. Can I say one more point about that?

Mr. Daub. Sure, and I'll be through in a minute.

Mr. Marmor. Insofar as people are outside of the workforce but under 65, and you postpone Medicare eligibility for a month (92 percent of them are insured but 8 percent of them are not), you produce this savings in the Federal budget at the risk of a few Americans who could be absolutely ruined by the mistiming of their illness. That seems to me poor social policy.

To the extent that the 92 percent are covered already, you don't deal with them. So transitional arrangements, it seems to me, should be more important than this 1-month tinkering.

Mr. Daub. I wouldn't object at all in terms of a more long-range policy idea, to be sure that in the transition we do take care of some points like you just made, and some problem areas where people would fall through the cracks.

But I am interested in the long term in the numbers of older people eligible for Medicare. Now if it's over 65, except for the disabled, and we proportionalize the FICA tax—you have suggested now that we may go after a little more of a portion for Medicare. We know that in the old-age and survivors fund, we're going to see surpluses in the next decade. The political question in 1996 may be how do we get our hands on that? Do we lower the FICA taxes on the worker, or do we look at the disability fund and the hospital fund and maybe move the percent of allocation to that trust fund over a little bit without raising the overall amount of tax taking out of that worker's paycheck?

The Christian Science Monitor had a very good story a couple of weeks ago. They said the aged population is 47 percent better off in terms of purchasing power over the last 10 years, while the worker is 7 percent less better off over the same period. So you see the indexing and the COLA clauses, and you look at Social Security and say we're going to pay you 8 percent if you keep working instead of quitting so soon. We're going to penalize you 30 percent if you quit sooner. We're going to make these incremental changes to try to shift the usefulness of society, since it's getting older, and few workers are coming on stream. There are going to be fewer people paying the FUTA/FICA taxes in this 20-year period from 1996 to 20 years out, as a percent of the total.

How would you get at the issue of private insurance contributions to this shift? Should we be careful not to do too much more in government, because the proof is that private insurance has been picking up more and more of the coverage of these costs in the last 20 years?

More and more people have pensions, have pension plans, have private insurance policies. Can we rely upon that private sector in the next 20 years to do a little more?

Mr. MARMOR. And do a little more for?

Mr. DAUB. The elderly and the costs of insurance over time.

Now you are a political scientist and I think it is useful for us to look at it that way, politically and demographically.

Mr. MARMOR. Actually, the political science field does not spend a lot of time worrying about Medicare, I must confess to you. They are worrying about other things. But as an analyst of Medicare over a long period of time, I think what you are getting at is whether or not the changed economic circumstances of the elderly as a group, as a whole, over time means that we might look differently at the mix between premiums, taxes, and other sources of revenue. Is that not right?

And the answer is that a thoughtful group of legislators ought, indeed, to do that. But when they do that, it strikes me that they want to be very attentive to the premium adjustments they make for the old, taking into account the sort of considerations that Mr. Gradison brought forth.

I would think, for example, that you would want to think about Medicare reform involving a part C premium or additional copayments that have to be subject to liability limits. We know that MEDIGAP policies, on balance, are poor buys. We can collectively provide a kind of liability limit through Medicare, which might be a very good buy, for an annual premium of between $100 and $150 per year, something on that order.

Well, I think that kind of change ought to be primarily financed by the elderly themselves. A good catastrophic plan is a reasonable bargain, it seems to me, for protection against financial disaster purchased for a monthly amount that is, on reflection, quite reasonable.

So if you are asking my general position, would it be worth worrying about, as we try to rationalize the benefit package, trying to define some sources of revenue from the elderly that can be defended as both fair and sensible, the answer is yes.

But I would not try to increase the payments of the elderly under co-insurance, at a time that I am slashing their benefits. That is not the way to do it.

The time to do it is when you are rationalizing the benefits, even if you are operating under constrained circumstances.

Mr. **Daub.** I appreciate your point. I look at the economy, generally, at a time when we have an unemployment rate that has declined somewhat and an inflation rate that has declined somewhat. If we could sustain those in other categories of our total economic picture, we may find ourselves in a window, if you will, of opportunity where we could make changes now, but not really implement them dramatically until future years, like some of the things we did in 1983. We could make those adjustment points in 1988, 1991, 1996, 2014, and start the planning for that now, as opposed to trying to do so much short-term budget work.

And I would just conclude by saying, Mr. Chairman, that I think we should—throughout this whole hearing—be a little careful when we simply aggregate the billions of dollars of changes over 5 years and sort of start thinking that they are all going to happen tomorrow morning.

This is a packaging of things—even the Medicare and Medicaid line items will increase as time goes by. So these changes may not appear to be all that dramatic.

I appreciate you being with us this morning and having the chance to engage your mind. Thank you very much.

Mr. **Jacobs.** Mr. Rangel?

Mr. **Rangel.** I have no questions.

Mr. **Jacobs.** Mr. Donnelly?

Mr. **Donnelly.** I have no questions.

Mr. **Jacobs.** Professor, Marmor, thank you for your contribution.

Will the next panel please come forward, Mr. DeLay, Mr. Hutton, and Mr. Fleming.

Mr. Delay, you may proceed in your own manner.

Everybody knows that we prefer that you summarize your statements, but we cannot make you do it.

STATEMENT OF FRANK DeLAY, BOARD MEMBER, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY CHRIS McENTEE

Mr. **DeLay.** On behalf of the American Association of Retired Persons, AARP, I want to thank you, Mr. Chairman, for this opportunity to present AARP's views on the administration's Medicare proposals for fiscal year 1987.

My name is Frank DeLay and I am a member of AARP's board of directors. AARP is the largest membership organization of older Americans, with 22 million members nationwide.

I would like to introduce my associate here, from the staff of AARP, Chris McEntee, who is appearing with me.

AARP believes that the administration's proposals to reduce Medicare spending by $4.7 billion in fiscal year 1987 are neither fair nor effective. The proposals are unfair because they reduce the deficit by significantly increasing beneficiaries' out-of-pocket expenses.

Older Americans now spend, on average, 15 percent of their annual income on health care expenses. Even in the absence of further increases in beneficiary cost-sharing, this percentage will grow to nearly 20 percent by the year 2000.

Despite these facts, the administration's Medicare proposals would directly add $645 to an individual's health bill and $1,290 to a couple's health bill through higher premiums and deductibles over the next 5 years.

Moreover, the administration's proposals to reduce provider spending, such as the change in the Medicare Economic Index which updates physician payments, will likely result in cost-shifting to beneficiaries, adding even more to their out-of-pocket expenses.

The administration's proposals are ineffective because they are based on program savings alone and do not lead to the creation of a more efficient health care system. We urge Congress to look beyond immediate Medicare budget savings and to adopt proposals which would reduce costs by correcting structural inefficiencies in the health care system rather than by shifting costs to beneficiaries and/or private payers of health care.

Nearly half the administration's Medicare reductions are accomplished through regulatory initiatives. Although many of these proposed rules contain reasonable policy objectives, AARP believes that substantive changes in Medicare merit full public debate and congressional scrutiny.

AARP believes that raising premiums and deductibles will not correct Medicare's part B spending problems. Rapid inflation in Part B is a direct result of physician payment methods which contribute to excessive price and volume increases. Therefore, we urge Congress to reform Medicare physician payment. We support the creation of a national Medicare physician relative value scale and improvements in Medicare's physician participation provisions.

We also believe that it is time to address the quality of care problems that have emerged as a result of past Medicare cuts and powerful incentives to providers to skimp on necessary care. We urge Congress to adopt legislation which would require discharge planning, ensure the availability of posthospital care, and enhance quality review. Such action would maintain quality care and assure beneficiaries that Medicare reductions are not just an excuse for the erosion of the Medicare Program.

Older Americans possess deep concerns about the inefficiencies inherent in the Medicare Program. We look forward to working with Congress on measures to improve efficiency in Medicare which will provide budget savings without eroding benefit protection.

Thank you.

[The prepared statement follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

before the

HOUSE COMMITTEE ON WAYS AND MEANS
Subcommittee on Health

on

THE ADMINISTRATION'S FISCAL YEAR 1987 MEDICARE PROPOSALS

March 6, 1986

Presented by:
Frank DeLay
AARP Board Member

Summary Statement

AARP believes that the Administration's proposals to reduce Medicare spending by $4.7 billion in FY'87 are neither fair nor effective. The proposals are unfair because they reduce the deficit by significantly increasing beneficiaries' out-of-pocket costs, a group already overburdened by rising medical expenses. Older persons now spend, on average, 15% of their annual income on health care expenses. Even in the absence of further increases in beneficiary cost-sharing, this percentage will grow to nearly 20% by the year 2000. Despite these facts, the Administration's Medicare proposals would directly add $645 to an individual's health bill and $1,290 to a couple's health bill through higher premiums and deductibles over the next five years. Moreover, the Administration's proposals to reduce provider spending, such as the change in the Medicare Economic Index which updates physician payments, will likely result in cost-shifting to beneficiaries, adding even more to their out-of-pocket health expenses.

The Administration's proposals are ineffective because they are based on program savings alone and do not lead to the creation of a more efficient health care system. We urge the Congress to look beyond immediate Medicare budget savings and adopt proposals which would reduce costs by correcting structural inefficiencies in the health care system rather than by shifting costs to beneficiaries and/or private payers of health care.

Nearly half the Administration's Medicare reductions are accomplished through regulating initiatives. Although many of these proposed rules contain reasonable policy objectives, AARP believes that substantive changes in Medicare merit full public debate and Congressional scrutiny.

AARP believes that raising premiums and deductibles will not correct Medicare's Part B spending problems. Rapid inflation in Part B is a direct result of physician payment methods which contribute to excessive price and volume increases. Therefore, we urge Congress to reform Medicare physician payment. We support the creation of a payment system based on a national Medicare physician relative scale and improvements in Medicare's physician participation provisions.

We also believe that it is time to address the quality of care problems that have emerged as a result of past Medicare cuts and powerful incentives to providers to skimp on necessary care. We urge Congress to adopt legislation which would require discharge planning, ensure the availability of post-hospital care, and enhance quality review. Such action would maintain quality care and assure beneficiaries that Medicare reductions are not just an excuse for the erosion of the Medicare program.

Older Americans possess deep concerns about inefficiencies inherent in the Medicare program. We look forward to working with Congress on measures to improve efficiency in Medicare which will produce budget savings without eroding Medicare's benefit protection.

On behalf of the American Association of Retired Persons (AARP), I want to thank you, Mr. Chairman, for this opportunity to present AARP's views on the Administration's Medicare proposals for FY'87. My name is Frank DeLay and I am a member of AARP's Board of Directors. AARP is the largest membership organization of older citizens, with 22 million members nationwide.

The Administration proposes Medicare reductions of $4.7 billion in FY'87. AARP believes that these proposals are neither fair nor effective. The proposals are unfair because they reduce the deficit by significantly increasing beneficiaries' out-of-pocket costs and ineffectual because they fail to correct structural inefficiencies in the Medicare program.

Beneficiaries have already suffered large cost increases in the name of deficit reduction and are overburdened by rising medical care expenses. Older persons now spend, on average, 15% of their annual income on health care expenses. Even in the absence of further increases in beneficiary premium and cost-sharing liability, this percentage will grow to nearly 20% by the year 2000. Despite these facts, the Administration's Medicare proposals would directly add $645 to an individual's health bill and $1290 to a couple's health bill through higher premiums and deductibles over the next five years. Moreover, the Administration's proposals to reduce provider spending will likely result in cost-shifting to beneficiaries, adding even more to their out-of-pocket health expenses.

The Administration appears to base its proposals on the achievement of program savings alone. To be effective, AARP believes that additional criteria, rather than program savings, must form the basis for evaluating proposals to reduce Medicare expenditures.

AARP questions the use of regulation rather than Congressional action as the mechanism to reduce Medicare spending. Regulatory initiatives comprise nearly half of the Administration's total Medicare reductions for FY'87. Although many of these proposed rules contain reasonable policy objectives, AARP believes that substantive changes in Medicare financing and coverage merit full public debate and Congressional scrutiny.

AARP's testimony addresses four areas:

1. the criteria for evaluating changes in the Medicare program;
2. several proposals to restructure Medicare which meet these criteria;
3. the problem of beneficiaries' rising out-of-pocket costs; and
4. an analysis of the Administration's FY 1987 Medicare budget proposals.

We urge the Congress to look beyond immediate budget savings in the Medicare program and adopt proposals which would reduce costs by creating a more efficient health care system for all Americans.

Criteria for Evaluating Medicare Changes

AARP believes that additional criteria, rather than simple program savings, are more relevant for evaluating proposals to cut the Medicare program.

First, any proposal to change Medicare must correct the structural inefficiencies in the health care system rather than merely shift costs to beneficiaries and/or private payers of health care. While there appears to be some recent improvement in the rate of increase in health expenditures, medical care price growth still climbs at about twice the rate of general economy inflation. Unless the forces driving health care cost increases are addressed, Medicare will continue to face efforts to achieve budgetary savings alone, without any attempt to create a more efficient health care system.

Second, any proposal to change Medicare should improve the insurance status of the program rather than simply erode benefits for the Medicare population. Additional increases in beneficiaries' out-of-pocket costs fail to address the fundamental forces driving health care cost inflation and have the most adverse effect on those enrollees least able to afford it, i.e., those who are very sick, the poor, and the very old.

Finally, any proposal to change Medicare must prevent the development of a two-tier system of care. Proposals which reduce only Medicare expenditures or change only Medicare benefits subject the elderly to the possibility of receiving less adequate care than that provided to the rest of the population. Unless the entire health care system is realigned, the elderly and their caregivers may find themselves at a significant disadvantage within our health care system. Based upon these criteria, the Administration's Medicare proposals for FY'87 are extremely short-sighted and do not represent health care reform.

Alternatives to the Administration's Medicare Proposals

AARP urges Congress to consider proposals which would improve efficiency in the Medicare program and prevent erosion of the Medicare benefit. Reforming physician payment and improving quality under Medicare's prospective payment system are two areas which deserve serious consideration.

AARP believes that Congress cannot adequately address Medicare's Part B spending problems until Medicare's physician payment policies are restructured. Rapid inflation in Part B is a direct result of physician payment methods which contribute to excessive price and volume increases. Raising Part B premiums and deductibles will not correct this problem. They would merely change who pays the bill.

The Association believes that reimbursement reforms based upon fee schedules, DRGs, and capitated payment, etc. for physicians hold the potential to dampen the rate of increase in physician expenditures and to establish a more rational and equitable method of physician payment than currently exists. Specifically, AARP supports the creation of a payment system based on a national Medicare physician relative value scale consisting of nationally defined units of service.

Coupled with pricing reforms, AARP supports improvements in the Medicare program's physician participation provisions, such as retaining financial incentives for participating physicians and providing periodic interim payments to participating physicians. AARP also supports reforms which enhance the role of Medicare as a prudent buyer of physician services such as prohibiting physicians who take assignment from billing patients for services Medicare finds to be medically unnecessary.

While a prospective payment system for physicians is being developed, AARP believes that interim reform of Medicare physician payment should be considered. In particular, steps should be taken to reduce the discrepancy in payment for technological over cognitive services, a discrepancy which has unnecessarily inflated physician care expenditures by fostering overutilization of technology-intensive procedures and by directing physicians into the more procedure-oriented specialties.

Moreover, Mr. Chairman, the Administration's Medicare budget proposals for FY 1987 fail to appreciate the erosion in the quality of care provided Medicare patients under PPS. In addition, five straight years of cuts has taken a toll on the Medicare program. It is time now to address the quality of care problems that have emerged as a result of program cuts and powerful incentives to providers to skimp on necessary care or supervised convalesence.

New legislation is necessary to ensure quality care under Medicare. Such legislation should include the following elements:

1. Discharge planning must be a condition of participation for hospitals in Medicare. The discharge planning team should ensure the patient's readiness for discharge and determine whether appropriate post-discharge care is available if it is required.
2. The continuity of quality care requires that Medicare patients needing post-acute care services transition from the hospital as smoothly as possible. Thus, the appropriate

level of post-acute care must be determined and the discharge destination assured. AARP believes this process requires that medically-based personnel, not insurers, make the initial determination for the appropriate level of post-acute care services and that that decision be made prior to discharge. Since PROs are physician-based organizations in all but one state, AARP believes that PROs are best suited to determine Medicare beneficiaries' eligibility for the appropriate level of post-acute care.

In those situations where the patient is determined to need post-acute care services, but the appropriate level of post-acute care is not available, the PRO must certify the patient for administratively necessary days (A.N.D.s) in the hospital.

3. Accessible, comprehensive data is essential to the task of both conducting quality review and evaluating its effectiveness. PROs must be given the resources to support access to and integration of multiple data bases. Moreover, we must continue to find ways to present PRO-generated data to consumers.

4. HCFA must be instructed to implement a severity of illness index that is easily used and sufficiently descriptive of the difference between patients within the same DRG.

The Administration's Medicare budget proposals for FY 1987 fail to address any of these crucial issues. AARP urges Congress to take action to maintain quality care for Medicare patients and assure program beneficiaries that the prospective pricing system is just not an excuse for the erosion of the Medicare program.

Rising Out-of-Pocket Costs

The Administration's proposals to reduce spending in Medicare are based on the notion that the elderly are not health cost conscious -- that they are somehow insulated by Medicare from the "true" cost of health care. Because of this insulation, so the theory goes, the elderly misuse or overuse the system and thereby increase Medicare costs. AARP rejects that theory. Medicare's coverage of health care needs, while adequate in certain areas, leaves the beneficiary at considerable risk in others.

Overall, Medicare pays for less than half of the elderly person's total health care bill. While Medicare covers about three-fourths of older persons' hospital bills, beneficiaries find themselves paying about 60% of their physician charges. Beneficiary out-of-pocket liability for medical bills is considerable and growing.

--In 1984, older Americans spent almost $10 billion to meet Medicare's cost-sharing requirements. This amount represents a 70% increase since 1981.

--In 1984, charges associated with non-assigned claims totalled $2.7 billion, representing a 100% increase since 1980.

--Beneficiaries experienced an 80% increase in their out-of-pocket liability for non-covered services and products between 1976 and 1981.

--Annual premiums for Part B coverage, which will total $186 in

1986, have risen by 116% since 1977.

Beneficiaries now spend about 15% of their total income on medical care, ironically, the same portion of their income that they spent prior to the establishment of the Medicare program. Further, even in the absence of any additional increases in cost-sharing or premium amounts, elderly out-of-pocket expenditures for medical care will likely reach 20% of income in 15 years.

Increases in health care costs for elderly persons cannot be linked to excessive utilization of services. Indeed, for persons over 65, hospital admissions have increased only slightly over time, while average length of stay has dropped dramatically. Further, per capita physician visits by elderly persons have also declined since 1974.

Increases in health care costs pose special problems for the elderly poor/near poor. A recent Health Care Financing Administration (HCFA) study found that out-of-pocket expenses expressed as a percent of income were six times greater for poor/near poor older persons than for their middle income counterparts. Moreover, fully one-fourth of the elderly poor/near poor are not protected by Medicaid. These persons are least likely to be spared the devastating effects of increases in health care costs in general, and in Medicare cost-sharing requirements in particular. Moreover, as elderly beneficiaries age, their medical expenditures tend to rise. Not only do average per capita Medicare reimbursements increase as older Americans age, but so do their out-of-pocket expenditures for health care. Indeed, beneficiaries who are 80 years old and older experience out-of-pocket medical costs that are 1 1/2 times those of persons 65 to 69 years of age. In addition, such increases occur as income declines; the average annual family income of persons 80 and older is only about 60% of the average annual family income of persons 65 to 69 years of age.

The Administration's FY 1987 Budget Proposals to Cut Medicare *<1>

The proposals which the Administration recommends in Medicare would impose new cost-sharing burdens on elderly Medicare beneficiaries and encourage providers to cost-shift to private payers (insurance and individual's). Among the proposals are the following:

* Delay in Eligibility for Medicare

FY'87: -.265

FY'87-89: -.890

This proposal would defer eligibility to the first day of the month following the month of the 65th birthday. This is the fifth year that the Administration has offered this proposal. Under current law, eligibility for Medicare begins on the first day of the month on which an individual's 65th birthday occurs. This proposal could create a gap in health insurance coverage for those who are age 65 but are not yet into the month following their 65th birthday. It would impact most severely on those needing acute care during this period.

* Increase Part B Premium

FY'87: -.725

FY'87-89: -5.8

This proposal, originally made by the Administration in its FY'84 Budget, would more than double the Part B premium by 1990 from

<1>All figures are in billions unless otherwise noted.

$186 in 1986 to $378 in 1990. Increased out-of-pocket costs (over current law) to Part B enrollee would be $470 while for a couple it would be $940 over the period 1987 through 1991.

If accompanied by a freeze in Social Security cost-of-living adjustments, as many in Congress keep proposing, it would almost certainly lead to reduced Social Security checks, since premiums are deducted from the Social Security check.

* Medicare Economic Index Freeze

FY'87: -.4

FY'87-89: -1.6

This proposal would decrease Medicare payments to physicians by recalculating the Medicare Economic Index (MEI). The MEI limits the yearly increases in Medicare "fee screens" for physicians' charges under Medicare Part B. This decrease comes on top at a 21 month freeze on Medicare physicians' fees. The practical effect of the MEI recalculation, on top of the recent Gramm-Rudman cut, will mean a freeze on most physicians' charges for the 3rd year in a row. Without the safeguards built into the current freeze, a reduction in Medicare "fee screens: for physicians will likely produce a drop in the Medicare assignment rate and higher costs to beneficiaries.

* Reducing Inequities in Physician Payments

This proposal would reduce Medicare "fee screens" for certain physician services, such as assistants at cataract surgery and anesthesiologists. The rationale for these reductions is that the actual cost for certain services has declined with advances in medical technology, while Medicare continues to pay an older, higher estimate of cost. Medicare "fee screens" for new procedures and services are determined by what physicians initially charge for these services. No mechanism exists to adjust "fee screens" as the cost of technologies or services decline over time. Reducing "fee screens" for certain services or procedures for which costs have declined since their introduction would bring "fee screens" into line with current costs. Such a mechanism could serve as a interim step towards Medicare physician payment reform.

* Increase Part B Deductible

FY'87: -.310

FY'87-89: -1.4

The Administration would increase the Part B deductible to $100 in 1987 and index the deductible to rise annually thereafter by the Medicare economic index. This would increase the deductible from the current $75 of Medicare "reasonable charges" to $100 in 1987 and approximately $4-5 per year thereafter. Each year, beneficiaries must first have absorbed $75.00 of charges based on Medicare's recognized charges. Thus it is usually more. This proposal merely taxes the sick at a time when the Administration is proposing no new taxes in order to reduce the deficit.

* Copayments for Home Health Visits

FY'87: -.100

FY'87-89: -.340

This proposal would establish copayments of 1% of the hospital deductible (or almost $5 a visit in 1987) for home health care visits. This proposal would penalize those who use a less costly form of care.

* Hospital Reimbursement Limit

FY'87: .455

FY'87-89: -1.6

This proposal would limit the increase in Medicare's DRG payments to hospitals to 2% instead of allowing an increase of market basket plus 1/4% (approximately 4 to 5%). At this point in the phase-in of the Medicare DRG program, it makes little sense to reduce DRG rates before we know what is really happening under the new system. A further tightening of Medicare payments could likely result in higher hospital charges for private payers as hospitals charge higher rates to these payers in order to regain lost Medicare revenues. Evidence is already mounting that Medicare beneficiaries are being discharged "quicker and sicker" from hospitals. Further tightening of Medicare would exacerbate this problem. Ultimately, a two-tier health system could result.

* Working Aged

FY'87: -.540

FY'86-88: -1.8

Under current law, workers aged 65-69 and spouses aged 65-69 of workers of any age, have the option of selecting employer-paid health insurance as their primary health insurance coverage, with Medicare as second payer. This proposal would lift the age limit and extend this option to any worker's spouse age 70 and above as well. Eliminating the age limit for the option of employer-paid health insurance coverage will raise the cost of employing older workers because the employer's health insurance carrier will likely raise its premium rates due to the additional risk of coverage for older employers and spouses. A strong disincentive to the employment of older workers is the likely result. Moreover, the accompanying loss of income tax and payroll revenue to the federal government could more than offset any savings achieved in the Medicare program through implementation of this proposal. Only through increased employment can older workers be expected to maintain financial independence, and thus, less dependence on government income support programs.

* Voucher

FY'87: +.050

FY'87-89: +.150

Under this proposal, Medicare beneficiaries would have the option of receiving a fixed sum or credit to purchase private health insurance in lieu of Medicare coverage. Establishing vouchers for Medicare beneficiaries would lead to the development of multiple health plans. National standards regarding covered benefits, quality safeguards, and appeal mechanisms would disappear.

Conclusion

Older Americans possess deep concern about inefficiencies inherent in the Medicare program. We urge Congress to adopt proposals which improve efficiency in the Medicare program, instead of those which simply reduce Medicare expenditures. Such proposals would produce budgetary savings without eroding Medicare's benefit protection.

CHART 1

Elderly Health Care Consumer Payments As a Percent of Mean Per Capita Income

		Per Capita Elderly Health Care Consumer Payments [1]	Elderly Mean Per Capita Income [2]	Elderly Health Care Consumer Payments As a Percent of Income
Pre-Medicare Period				
	1966:	$300	$2000	15%
Medicare Period				
	1977:	$698	$5,592	12%
	1981:	$1,198	$8,638	14%
Projected:	1984:	$1,550	$10,615	15%
	1989:	$2,208	$14,082	16%
	1993:	$2,892	$17,311	17%
	2000:	$4,637	$24,843	19%

Sources: HCFA, U.S. Bureau of the Census, Thomas C. Borzilleri Memorandum, November 4, 1983

[1] Includes out of pocket costs plus premium payments

[2] [illegible] to mean per capita income of those 65 and older

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Mr. JACOBS. Mr. DeLay, you are beautiful. You did it within 5 minutes. Very few witnesses do that. I know that is going to be persuasive with the committee. [Laughter.]

Mr. Hutton, I believe you are next on the list. Let us see how well you can do.

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. Thank you.

Mr. Chairman, my name is William R. Hutton. I am executive director of the National Council of Senior Citizens, which represents over 4.5 million of America's elderly. The majority of our members are Medicare beneficiaries.

Mr. Chairman, I would prefer just to occupy the next few minutes with highlights and ask you to put the entire testimony submitted into the record.

Medicare funding has already been cut by $21 billion through reductions approved between fiscal years 1981 and 1985. Now President Reagan is asking for additional reductions, $57.5 billion over the next 5 years.

The President's fiscal 1987 budget, that plan—including the 5-year projections—asks Congress to approve $33 billion or 57 percent of this massive Medicare reduction; $21 billion out of the $33 billion, or 64 percent, would be derived directly from increased costs to beneficiaries.

The President states, in his budget message to the Congress, that his budget plans meet the Gramm-Rudman-Hollings deficit reduction targets "without raising taxes, without sacrificing our defense preparedness, and without cutting into legitimate programs for the poor and elderly."

Is Medicare not a legitimate program? Is a $57.5 billion reduction not a cut?

As we examine the President's budget, we realize that one of the vehicles the President used to meet Gramm-Rudman, while giving the military an 8-percent increase over inflation and refusing to increase revenue, was to gouge Medicare and tax the beneficiaries.

We are very concerned about the impact of cutting a total of $57.5 billion from Medicare will have on beneficiaries.

My written statement, which I have submitted for the record, focuses on the legislative proposals which will have the most direct effect on the Medicare beneficiaries. These are the proposals to increase the part B premium and deductible, impose copayments on certain home health, and ambulatory care services, and delay initial eligibility for benefits.

These are the proposals which will ask Medicare beneficiaries to pay $21 billion over the next 5 years out of their own pockets. This additional money is not to improve Medicare at all. We are not buying anything new, we are paying for the Presidential deficits.

In your hearing last week on the need for catastrophic health coverage, during which we testified, you and your committee members heard of the financial burdens that Medicare's mandatory cost sharing levels, long hospital stays, and chronic- and long-term-care costs impose on the aged and their families.

We are encouraged by your interest in legislation that will help ease these burdens.

Today, sir, we make our most urgent appeal to you and the committee members to view the President's proposals in light of beneficiaries' current expenses and the Medicare Program's limitations to meet their needs.

We urge you not to try to force a fit between Medicare and the President's budget or fiscal priorities. Medicare and its beneficiaries are vulnerable to budget cutting, not because they do not fit the President's definition of legitimate, they are vulnerable because of the President's intransigence on taxes and military spending growth which has forced Congress to look to dwindling domestic spending resources for funding his priorities, which have tripled the deficit.

As I say one last word, Mr. Chairman, reimbursement reform can be a major source of budget savings. Other steps, such as controlling fraudulent or unnecessary delivery of service as well as assuring that Medicare funding is not wasted on profit, could enable Congress to keep Medicare savings where they belong, in the program.

[The prepared statement follows:]

The President's FY 1987 Medicare Budget Proposals
Impacts on Beneficiaries

Statement by

William R. Hutton, Executive Director
National Council of Senior Citizens

Before the Health Subcommittee
U.S. House of Representatives Committee on Ways and Means

March 6, 1986

Mr. Chairman, my name is William R. Hutton. I am Executive Director of the National Council of Senior Citizens. The National Council represents over 4.5 million of America's older people. The majority of our members are Medicare beneficiaries. We are deeply concerned about the direction the President would take us with his proposed Federal budget for fiscal years 1987-1981. We appreciate the opportunity to discuss with you today our concerns about the proposals directed toward the Medicare program.

Our concerns about the President's FY 1987 budget are not limited to Medicare or health programs, though we certainly have enough to worry about as we look at proposals for Medicare, Medicaid, veterans' health care, and public health service programs. We are very worried about the immediate and long-term effects the President's plans will have on all generations--on families with young children who need help to receive decent nutrition, education, and health care; on workers struggling to find or keep their jobs; and on elderly trying their best not to burden their children.

As a fiscal blueprint, the Federal Budget should reflect the nation's policy priorities. Does the FY 1987 truly speak for the nation, or is it merely a vehicle for the Reagan Administration to meet its military growth and government cutback priorities at the people's expense? This is a question we think Congress should ask as members examine the President's plans. We also urge you to ask not "where to cut" but "why" to cut domestic programs in view of the many fiscally and socially responsible alternatives which can be adopted to reduce the deficit.

We recognize that the Federal deficit growth must be controlled. One step toward reaching this goal is a re-ordering of Federal budget and fiscal priorities. The National Council of Senior Citizens encourages Congress to take this step. However, we ask that the FY 1987 "steps" not take us in the same direction as those adopted during the last five fiscal years. Those are the steps that more than tripled the deficit, bringing us to deficit levels which exceed $200 billion. Those are the steps which are now forcing Congress to ask once again, "Where and how should we cut Medicare funding?"

It is time for new questions, new answers, and new steps. It is time to ask, do the American people really want Congress again to shift the nation's resources from its people to the military? Do we really want Congress to sanction a continued drain on the Federal Treasury through wealthy corporations' tax loopholes and special preferences? Should Congress continue to cut back on domestic programs to fund an unprecedented peacetime build-up of the military, using the Federal deficit as an excuse?

Senior citizens across the nation are asking Congress to answer "no." However, the President is once again asking Congress to answer "yes" to these questions. His FY 1987 Medicare budget proposals provide dramatic evidence of his policy priorities.

Medicare funding has already been cut by $21 billion through reductions approved between fiscal years 1981-1985. Now President Reagan is asking for additional reductions--$57.5 billion over the next five years. This amount is $5 billion higher than the total cost of the entire Part A, Hospital Insurance program in 1985.

The President's FY 1987 budget plan asks Congress to approve $33 billion, or 57 percent, of this massive Medicare reduction; the remainder would be cut through regulatory changes. Twenty-one billion dollars out of the $33 billion, or 64 percent of the Medicare budget gutting responsibility that the President is shifting to Congress, would be derived directly from increased costs to beneficiaries. New premium revenue, to be paid primarily by Part B enrollees, would account for $17.2 billion of this $21 billion.

The first year of the President's five-year plan will cut $5 billion from Medicare's funding under current law. The dollar amount and percent of reductions will increase thereafter at an increasing rate culminating in a $17.4 billion cut scheduled for the fiscal year 1991. Although the President's plans are aimed at providers as well as beneficiaries, the beneficiaries can be affected by cuts in both categories. Experience during the last few rounds of budget reductions has shown us that increased out-of-pocket costs are not the only impacts which beneficiaries encounter. Erosion in access to medical services and quality of care are also significant undesirable effects.

Thus we are very concerned about the impact that cutting a total of $57.5 billion from Medicare will have on beneficiaries. We urge this Committee and all members of Congress to consider the consequences of such cuts as they assess the proposals. Our focus today, however, is specifically aimed at the most direct and egregious legislative plans aimed at beneficiaries.

- Increase the Part B Premium

The percentage of Part B total program costs paid by beneficiaries through the premium would increase by two percentage points each year for five years. The beneficiaries' share would rise from the current 25 percent to 35 percent. FY 1987 funding reduction: $725 million; five-year projection (FY 87-91): $17.2 billion.

Impact on Beneficiaries

The Federal share of funding the Part B program would drop from the current 75 percent to 65 percent, as the elderly's share would rise to 35 percent. In this process, the government would shift $17.2 billion in higher premium costs directly to beneficiaries.

The current premium is $15.50 per month ($186 per year), deducted from Social Security checks. Under the President's plan, by 1991 it could reach $37 per month ($440 per year) compared to the monthly level of $20.70 ($248 per year) which it is projected to reach under current law. The proposed 1991 rate is 77 percent higher than it would be in 1991 without the President's proposed change. The new rate will rise even higher if program costs exceed estimates.

The Part B program is described as "optional" because the beneficiary can choose not to pay the premium, thus not receive Part B coverage. If the increase is adopted, many elderly may view it not as "optional," but unaffordable, and possibly drop their coverage, thus loosing financial access to non-acute health care services and physician care.

The proposal also includes a provision to increase immediately to 50 percent the share of the program costs paid in premiums purchased by "third parties." These include state Medicare programs and employers, who would be forced to pay an additional share of the government's costs. The plan would increase state Medicaid costs at a time when Federal Medicaid funding would be cut.

- Increase the Part B Deductible

On January 1, 1987, the President would raise the annual Part B deductible from the current $75 to $100, a 33 percent increase. The deductible would increase annually thereafter according to the medical economic index. This index is currently used to increase physician reimbursement rates. FY 1987 funding reduction: $310 million; five-year projection (FY 87-91): $3 billion.

Impact on Beneficiaries

Medicare beneficiaries would have to pay $25 more in charges for Part B covered services before Medicare reimbursement begins. They would be required to pay approximately $5 more each year thereafter before meeting the required deductible. The 1991 deductible could reach $120.

The Part B deductible is only one of two required under Medicare. The Part A deductible is $492. While the latter affects about 25 percent of beneficiaries (those who are hospitalized), the Part B deductible affects nearly 75 percent. Elderly people need the physicians' and out-patient services covered under Part B. However, the rising deductible is expected to become an increasing barrier to seeking these services, which provide not only access to the health care system, but to services that can prevent or reduce hospital use.

- Institute Home Health Care and Ambulatory Surgery Co-Payments

Medicare beneficiaries receiving reimbursable home health skilled care services without having first been admitted to a hospital or skilled nursing facility would be charged a co-payment for each visit. The co-payment would equal one percent of the Part A deductible. Beneficiaries receiving services in ambulatory surgical centers would be required to pay 20 percent of Medicare's reimbursement rate. FY 1987 spending reduction: $110 million; five-year projection (FY 87-91): $690 million.

Impact on Beneficiaries

Current law requires no co-payment under Parts A or B for home health skilled care services. In 1981, Congress discontinued the co-payment previously required in order to encourage use of alternatives to institutional care. Coverage is strictly limited to individuals who are homebound and need skilled care on an intermittent basis. Similarly, no co-payment is required for ambulatory surgery centers.

The home health co-payment will be $5 in FY 1987 and will rise yearly with increases in the Part A deductible. By FY 1991, Medicare beneficiaries will pay out of their own incomes nearly $700 million which, under current law, is the government's responsibility. Similarly, patients who undergo surgery as out-patients will pay a co-payment for care now reimbursed at 100 percent.

These plans are much more than benefit cuts and added expenses to senior citizens. They are also steps which are contrary to Administration-supported cost-containment and quality assurance policy. Reducing the use of institutional care and providing out-patient service, including surgery, are components of this policy. Instituting new co-payments penalizes the beneficiary and also may provide disincentives for the appropriate use of non-hospital medical care.

- Delay Initial Eligibility for Benefits

Under current law, Medicare coverage begins on the first day of the month in which an individual reaches age 65. The proposal would postpone eligibility until the first day of the month after the 65th birthday. FY 1987 funding reduction: $265 million; five-year (FY 87-91) projection: $1.620 billion.

Impact on Beneficiaries

The President's plan would place at risk individuals with limited or no access to private health insurance. The Administration assumes that employers' health benefits will fill the potential month-long gap in coverage. However, over the last three fiscal years, billions of dollars in Medicare costs have been shifted to employers and private insurors to cover working aged and will continue to be shifted if FY 87 plans are adopted. There is no assurance that employers will continue to pay or additionally pay for another month's coverage.

Unemployed and under-insured individuals and women who lose private insurance when their husbands die or retire await the month of their 65th birthday in order to be finally insured through Medicare. Waiting an additional month could result in a longer period without coverage, another month of paying high individual premiums, or incurring unaffordable medical bills if medical care is required.

Mr. Chairman, these Medicare funding reductions are being discussed as the first Gramm-Rudman-Hollings sequester goes into effect. This legislated deficit reduction vehicle will have marked effects on the Medicare budget and the program's 30 million beneficiaries. That Medicare is a category IA program under Gramm-Rudman is of little comfort to beneficiaries.

First of all, the President states in his budget message to the Congress that his budget plans meet the Gramm-Rudman-Hollings deficit reduction targets..."without raising taxes, without sacrificing our defense preparedness, and without cutting into legitimate programs for the poor and elderly." (Last underscoring added.) Is Medicare not a "legitimate" program? Is a $57.5 billion reduction not a cut?

The National Council of Senior Citizens believes that asking for a $57.5 billion reduction in program funding and a $21 billion out-of-pocket burden belies the President's proclamation. As we examined the President's budget, we realized that one of the vehicles the President used to meet Gramm-Rudman, while giving the military an eight percent increase over inflation and refusing to increase revenue, was to gouge Medicare and tax the beneficiaries.

Secondly, the Gramm-Rudman provider-directed cuts of one percent in 1987 and two percent thereafter will have secondary impacts on beneficiaries. The impacts will be exacerbated by additional cuts made through budget reconciliation. The automatic cuts are to be made only in provider payments, not in benefits. However, providers currently forced to deal with reimbursement freezes and their extensions may be unwilling to accept Medicare patients, reducing access. Other providers may refuse to sign participation agreements, reducing the availability of physicians and suppliers willing to accept assignment.

Medicare contractor funding is also being reduced by the March 1 sequester order. A consequence of this cut and an alleged directive from the Health Care Financing Administration is that contractors will pay claims at a slower rate. This applies not just to doctors, hospitals and other providers, but to beneficiaries who file their own claims for bills from doctors and medical suppliers who do not accept assignment (30 percent of claims are filed directly by beneficiaries). With out-of-pocket expenses so high already, waiting for reimbursement will be an unfair additional burden.

The National Council of Senior citizens is very pleased, Mr. Chairman, that you are concerned about the high and continually rising out-of-pocket expenditures that older Americans experience in spite of access to Medicare, Medicaid and private insurance. In your hearing last week on the need for catastrophic health coverage, during which we testified, you and your Committee members heard of the financial burdens that Medicare's mandatory cost-sharing levels, long hospital stays and chronic and long-term care costs impose on the aged and their families. We are encouraged by your interest in legislation which will help ease these burdens.

Today, we make our most urgent appeal to you and the Committee members to view the President's proposals in light of beneficiaries' current expenses and the Medicare program's limitations to meet their needs. We urge you not to try to force a fit between Medicare and the President's budget or fiscal priorities.

Medicare and its beneficiaries are vulnerable to budget cutting not because they do not fit the President's definition of "legitimate." They are vulnerable because the President's intransigence on taxes and military spending growth have forced Congress to look to dwindling domestic spending resources for funding his priorities which have tripled the deficit.

We are not discouraging the Committee from looking at Medicare for savings. However, we ask that you do so very cautiously. Consider not just beneficiaries' out-of-pocket burdens, but also where or how Medicare outlays can buy quality medical care more efficiently. For example, hospital reimbursement has been reformed to a prospective system. Although not without fault and in need of close scrutiny, the system can be credited with controlling outlay growth. The need for physician and other provider reimbursement reform is urgent.

Reimbursement reform can be a major source of budget savings. Other steps, such as controlling fraudulent or unnecessary delivery of service, as well as assuring that Medicare funding is not wasted on profit, could enable Congress to keep Medicare savings where they belong--in the program.

Mr. JACOBS. Perfect. That is 3 seconds short of 5 minutes.

Dr. Flemming, we are especially honored to have you here, the former Secretary of Health, Education, and Welfare and well known for your erudition and your dedication to good, clean public policy.

We are particularly honored to have you here, sir.

STATEMENT OF ARTHUR FLEMMING, COCHAIRMAN, SAVE OUR SECURITY COALITION

Mr. FLEMMING. Thank you, Mr. Chairman.

I regard it as a privilege to, once again, appear before this committee.

My name is Arthur Flemming and I am here representing SOS, a coalition of over 100 national organizations to protect Social Security. I serve as cochair of SOS and Wilbur Cohen is the other cochair.

I have listened to the testimony this morning and I am delighted that, in connection with the questioning, the committee has shown a very real interest in some of the broader issues that are involved in a consideration of the President's budget proposals. And I would like, just briefly, to indicate where SOS stands on those broader issues.

First of all, we do support the thrust of the cost containment legislation that is pending in both the House and the Senate. We feel that we can profit by the experience that we have had under part A of Social Security and move forward in that particular area.

Then, we support the telescoping of part A and part B into one trust fund. Now I appreciate that raises a lot of issues including the issue of financing. But that is our position.

And then we do support, as the basic fundamental solution to these issues, the enactment of a national health plan. And as we understand it, a task force will be coming up with a new proposal along that line, drawing to considerable extent on the Canadian experience, within the next few months. And I assume that that will undoubtedly be introduced as a bill and I certainly hope that the Ways and Means Committee will give consideration to that proposal.

But addressing myself to the President's budget proposal, I want to say that we are deeply concerned about the impact on older persons of the implementation of the Medicare recommendations in the President's budget.

We know that if the proposed increase in premiums under part B should be put into effect, for example, that taking the Nation as a whole, older persons' out-of-pocket health care costs as a percentage of mean income is going to be far closer to 20 percent than the 1984 estimate of 15 percent. We would definitely be moving in the wrong direction, as we have been doing since 1981.

We are especially concerned about the impact of the Medicare budget recommendations on older persons who fall below the poverty line.

The recommendation that to raise the Medicare premium over a period of 5 years from 25 percent to 35 percent of part B costs would mean that by 1991, Medicare beneficiaries would be required to pay $191 more a year for coverage than is the case at the present time. This would represent a substantial percentage of the total income of the elderly poor.

It is true that State Medicaid programs are allowed to pick up the premium costs for the low-income elderly who are enrolled in Medicaid, but two things must be kept in mind. First, only 39 percent of older persons below the poverty line are enrolled in the Medicaid Program. Second, not all States pay the premiums for those who are on Medicaid, and there is included in the budget a disincentive for increasing State involvement, namely, that when they pay the premiums for Medicaid beneficiaries, they would be required to pay 50 percent, not 35 percent of the costs.

The result is that if these increases go into effect, about two-thirds of the elderly poor, over 2 million persons, will have to pay the increases out of their own pockets.

It seems to us that the proposal is just another device for reducing benefits for all persons under the Medicare Program, reducing them at a time in life when they need them the most. As far as the old or poor are concerned, it is an unconscionable proposal, totally lacking in compassion. Unfortunately, it is another example of how we as a nation are moving backward instead of forward in giving preferential consideration to the poor.

Thank you very much.

Mr. **Jacobs**. Thank you, Dr. Flemming.

Mr. Gradison.

Mr. **Gradison**. I have no questions.

Mr. **Jacobs**. Mr. Rangel.

Mr. **Rangel**. I have no questions. A very enlightening and well-thought-out statement.

Mr. **Jacobs**. The committee expresses its gratitude for the conciseness. One remembers the utterance of Woodrow Wilson in his apology for writing such a long letter because he didn't have time to write a short one.

Dr. Flemming, I think you referred to a 50-percent figure. At the outset of Medicare in 1965, that was the concept for the premiums, was it not?

Mr. **Flemming**. Yes; I think that is true. But as you know, as time has moved on, we moved below the 25 percent at one point, and now we are up to the 25 percent.

My objection or our objection to that is that it seems to us that the requirement that States pay 50 percent of the cost for Medicaid recipients would constitute a disincentive to the States to pick up this cost as far as the Medicaid recipients are concerned.

Mr. **Jacobs**. Well, I participated in the creation of the Medicare Program in 1965, and I think the wild card was that nobody dreamed, that I knew of, in those days of the disproportionate inflation in the cost of Medicare part B at the outset. I recall we thought maybe a worker could set aside a few beers a week and instead pay a little bit of money into the Medicare fund, and that was part A, of course, and then that the other would be fairly reasonable, too.

There has been a disproportionate inflation, has there not, in part B costs?

Mr. **Flemming**. That's right.

Mr. Chairman, I appreciate that from a logical point of view, there could be a defense of this, but what we are looking at, really, is the burden on older persons at the present time.

May I just say this? I was also testifying 20 years ago on Medicare. I chaired a commission of private citizens that President Kennedy and Senator Javits and Senator Anderson asked to have set up, and actually, our commission came in with a proposal which is very similar to part B as it was finally enacted.

But as time has gone on, I am personally not happy with the concept underlying part B, and that is why I endorse personally very enthusiastically the position taken by SOS that we come to grips with the possibility of telescoping part A and part B into a single trust fund because I recognize that part B is not social insurance; whereas part A is.

I mean part A is a genuine social insurance program; part B is not. And it seems to us that at this particular time, to put increasing burdens on the older persons in connection with health care is not defensible.

As we know, the trust fund to part A is all right into the 1990's. It seems to us that this is a good time to take the necessary actions to bring part B under social insurance.

Mr. Jacobs. Yes. I think that there might be some logic in returning to the 50 percent figure if you could also find logic in the Government's allowing the runaway inflation which, as I say, was quite disproportionate to the other inflation in the economy, particularly in part B.

I yield to Mr. Gradison.

Mr. Gradison. Dr. Flemming, how would you feel about the increase to 35 percent if it were so drafted that the low-income elderly that you very properly are particularly concerned about were exempt from the increase?

Mr. Flemming. Obviously, we are very concerned about the low-income elderly, but it seems to me, Mr. Gradison, here we have got another situation where older persons are making their financial plans on the Medicare benefits as they now exist, and to force them to invest more of their own income in health care costs, I think, is wrong.

Mr. Gradison. Regardless of their income?

Mr. Flemming. Yes; because it seems to me, although this isn't a pure social insurance program—I recognize that—I still think that we ought to try to keep in the picture the degree of certainty that we have all tried to achieve under a social insurance program. That's one of the benefits of a social insurance program; namely, that people pay into it and then, having paid into it, when they confront some of these hazards and vicissitudes, as President Roosevelt referred to them, they can count on certain benefits.

And say what you will, if we move it up to the 35 percent, we are reducing benefits. I just don't think that this is a time to reduce benefits for any of the older persons.

I appreciate the issue that is raised about high-income persons and their ability to pay the 35 percent. Sure, they could pay it, but look, if we are worried about these high-income people getting too much, I would say let's get at that through the tax reform bill.

This committee came to grips with that particular issue and you did include provisions that will result in some high-income persons paying a higher tax, and that is the way, it seems to me, to get at that, rather than to distort the concept of social insurance by making it necessary for people with higher incomes to pay a different premium.

Mr. **Gradison**. I understand. I guess it is basically a philosophic problem that I have. We have gone through program after program, school lunch, student loans, and so forth, and said, hey, friends, we only have so much money around for subsidies, let's make sure it goes to the people who really need it.

I just have trouble with the logic that the general taxpayer should pay 75 percent of the part B premium on a program which is optional—it is not a social insurance program—on the part of those who could easily afford to pay 100 percent and for whom 100 percent would be a bargain because they couldn't buy anything comparable in the private market.

I understand your point, Dr. Flemming, and I don't want to belabor it, but I honestly think that part of the reason we are in the budget difficulties we are is that in program after program, the position has been taken that once a program is on the books it shouldn't be changed. We don't want to distinguish between the one group and the other group, that that would be an invidious comparison. And the result is, in part, $200 billion deficits.

Mr. **Flemming**. I understand your point. I guess my hope is that you and the other members of the committee would give serious consideration to telescoping part A and part B into one trust fund and then confront the financing issues that are involved in that.

I think that would help to clear up the picture, and I think it would help to provide older persons with a much better protection than they have at the present time. That is the way I would like to get at it.

Mr. **Gradison**. That is a valuable suggestion, and I appreciate the testimony of all the panel. Thank you very much.

Mr. **Jacobs**. Dr. Flemming, the one point you made there about the tax reform bill, are you laboring under the impression that it has reduced taxes of wealthy people in the United States?

Mr. **Flemming**. The thrust of the tax reform bill is one that I like very much because you would take many of the low income off the tax rolls; namely, 6.5 million. I think my figure is correct there. I think that is great. At the same time, you have put an additional burden on some of the high income.

Mr. **Jacobs**. I don't know which high income you have in mind. The tax so-called reform bill that passed the House of Representatives knocks $30,000 a year off the President's own personal income tax. That's not exactly treating him unkindly. Of course, it was his proposal, so maybe it is understandable.

Mr. **Flemming**. Mr. Chairman, I guess the group that I had in mind was the individuals and corporations who had not been paying any taxes. You did include a minimum corporation tax, if my recollection is correct. I thought you included a minimum tax as far as wealthy individuals were concerned.

Mr. **Jacobs**. That is exactly the impression the administration wanted you to get. I just wanted to see how efficient they are. If they can fool you, I am really worried.

Mr. **Flemming**. Well, isn't it true that some of the persons, some of the wealthy who were escaping taxation completely would not escape it completely under the bill as it passed the House?

Mr. **Jacobs**. Well, if you can find some of them, as old Gene McCarthy used to say, name them to me.

Mr. **Flemming**. Well, I notice Congressman Gradison nodding his head in approval there. I think that——

Mr. **Jacobs**. We are probably drifting into a foreign subject here.

Mr. **Flemming**. I'm sorry.

Mr. **Jacobs**. It's my fault.

Mr. **Flemming**. Well, don't misunderstand me. I would go further than the bill did, but my understanding was that some of those who were escaping completely would have to pay something. Now, you and I probably would agree that they are not going to be paying enough.

Mr. **Jacobs**. The Chairman of General Dynamics, by the bill proposed by the President, gets $190,000 a year knocked off his taxes; but of course, with a big surplus in the Federal budget, there is no reason why he shouldn't since most of his money is made from the Federal budget.

But we thank the panel for its contribution to our deliberations here.

Our next panel is led off by our friend Jack Owen, executive vice president of the American Hospital Association, and then the subpanel on reduction in Medicare education payments, Association of American Medical Colleges, represented by Charles O'Brien, Jr., Georgetown University Hospital, and we have Dr. Janet Freedman and the National League for Nursing by Ms. Nancy Powell, registered nurse.

So Jack, I guess you are our leadoff witness.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. **Owen**. Thank you, Mr. Chairman.

I apologize if my voice breaks. I have a cold.

I would like very quickly just to express our concern about the budget and what is happening in light of the testimony that you have had previous to my testimony on the problem that the hospitals have with this budget, as well as the elderly.

There is no question but we have supported the administration and we have supported the whole concept of a prospective pricing system to save trust funds, and that has been accomplished. Where we are caught now is that the prices keep getting dropped on hospitals and yet no benefits or services are being asked to be taken away.

We are expected to continue to deliver care as if nothing had happened.

The administration proposes to cut the Medicare hospital budget by some $22 billion over these next 5 years, and in 1987 alone, that cut is $2.75 billion, and that is limiting the DRG increase to 2 percent. It is limiting direct medical education payments and it is cutting in half indirect payments and folding capital in, as we discussed at the last hearing.

All of these are real cuts to hospitals. They are not just cuts on growth of program. In each of the past 5 years, Congress has passed legislation that has made reductions in the Medicare budget of some $45 billion by 1988, and yet we haven't had a chance to live with those cuts before we are getting cuts of the next year.

Hospitals have been operating under a freeze since 1984. Their payments were reduced by 1 percent effective March 1, 1986, and we are going to be faced now with delivering the same service for less dollars at the end of this year.

In real terms, Medicare hospital payments are 8-percent lower than inflation over the 1986 period, and I might say that even though we have heard about hospitals that are making money, over one-half of all hospitals experienced operating losses during 1984 in their patient care services, and over one-fifth experienced an operating loss of over 6 percent or more.

We are now going into 1987. It looks at best like we might get a 2-percent increase. If Gramm-Rudman takes effect, we probably won't get even an increase there. We are asked to deliver the same amount of care. It is coming to a point where I think Congress and the administration must recognize that we are going to have a problem of access and a problem of quality.

There is no way that we can continue to care for patients for the same dollars as inflation goes up even 4 or 5 percent, cutbacks on programs, and still expect that the same degree of quality can be delivered to our patients. It is not the hospitals that get hurt; it is going to be the patients, in the long run. We are going to hear of more hearings from Senate Aging about quicker and sicker discharges.

It is going to happen, but I see no way out of it unless we can come to some realization that that trust fund which has been saved through the year 2000 is not the sole problem of what health care issues are, and that the issue of the budget goes beyond just the Medicare trust fund, and that we establish a program for delivering health care on the basis of what is needed and a fair price, and let us get on and do that for the patients that we want to serve.

I will stop right there. I know there are some other witnesses here who have some specific things they would like to bring out, Mr. Chairman, and I will stop at this point.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
ON
THE ADMINISTRATION'S FISCAL YEAR 1987 MEDICARE BUDGET

MARCH 6, 1986

SUMMARY

The Administration's Fiscal Year 1987 Medicare budget request calls for Hospital Insurance (HI) spending of $49.9 billion, a cut of $2.75 billion from planned FY 1987 spending levels. To achieve this reduction the budget calls for cuts in the direct and indirect medical education payments, cuts in payments for capital expenses, a limit on the increase in Diagnostic Related Group (DRG) payments, and other reductions. In each of the past five years, Congress has passed legislation making reductions in Medicare spending estimated by this committee to total $45 billion by 1988. The American Hospital Association (AHA) estimates that changes due to the new Prospective Payment System (PPS), decreases in patient volume, limits on PPS-exempt hospitals, and the general decrease in inflation will account for Medicare savings of $13 billion by the third year of PPS. Hospitals are currently operating under the same payment rates and rules that were in effect in October, 1984. The Health Care Financing Administration (HCFA), on September 3, 1985, published final regulations that, unless Congress acts, will take effect on March 15, 1986 and will continue the freeze on FY 1986 hospital payment rates at the FY 1985 level while changing the formula for calculating individual hospital payments to eliminate 25 percent of the hospital specific cost. Effective October 1986, PPS payments will be based on national average costs with no hospital specific costs taken into account. This change in the Medicare prospective payment transition, taken by itself, will contribute to even worse financial situations for a significant number of hospitals already operating at a deficit in their patient services area. Over one half of all hospitals experienced operating losses during 1984 in their patient care services, and over one fifth experienced an operating loss of 6 percent or more. Cuts in Medicare's fair share of the cost of providing graduate medical education will hamper hospitals in their efforts to continue to provide quality health care to the nation's Medicare beneficiaries. The continued insistence by the Administration on arbitrary cuts in Medicare spending, as proposed in its FY 1987 budget, will dangerously strain the ability of hospitals to continue to provide high quality health care to nearly one in five Americans that will benefit from the Medicare program in 1987.

INTRODUCTION

Mr. Chairman, I am Jack W. Owen, Executive Vice President of the American Hospital Association, and I am pleased to have this opportunity to present the Association's views on the President's Fiscal Year 1987 Medicare budget on behalf of the Association's 6,100 health care institutions and 38,000 personal members. The Medicare prospective pricing system's underlying principle, price-setting through a formula recognizing the changes in productivity, technology, and resource prices that constitute hospital expenses, is falling victim to federal budget slashing. Mounting federal budget pressure and the fundamental reform imposed by the Gramm/Rudman/Hollings balanced-budget legislation threaten to compromise PPS' viability, as well as payments to PPS-exempt facilities. Additionally, the system continues to experience growing pains, which will intensify as the transition to fully federal rates progresses. And though some of PPS' original inequities have been corrected, design flaws remain, with large, growing gaps between "winner and loser" hospitals. If PPS is to be equitable for hospitals and beneficiaries, fair market prices must be offered for hospital Medicare services.

HOSPITALS' FINANCIAL CONDITION

Since the implementation of PPS, Medicare prices have been increased by less than that necessary to reflect the effects of inflation on hospital costs. Prices for the remainder of FY 1986 will be rolled back by 1 percent. By contrast, during FYs 1985 and 1986, HCFA estimates that inflation increased the cost of labor, goods, and services needed by hospitals to care for patients by more than 10 percent. Thus, in real terms, Medicare hospital payments have fallen by more than 8 percent over FYs 1985 and 1986. The Administration budget proposes to increase prices for FY 1987 by no more than 2 percent, an amount substantially less than inflation expected next year.

In addition, if Congress and the President are unable to agree on a plan to reduce the deficit to the $144 billion level required by the Gramm/Rudman/Hollings law, Medicare payments to hospitals will be reduced automatically by 2 percent effective October 1, 1986. This would amount to a reduction of 3 percent below the FY 1985 level of payment.

In 1982, at the time that the Tax Equity and Fiscal Responsibility Act was enacted, projected Medicare expenditures for 1984 were $46.5 billion. The 1984 annual report on the status of the Medicare Trust Fund revised the 1984 projection to $44.5 billion, a reduction of $2 billion, and projected expenditures of $52 billion in FY 1985, and $57 billion in FY 1986. Actual expenditures have been consistently below these projections: $42.1 billion in

1984 and $48.7 billion in 1985. The most recent report of the trustees projects expenditures of $49.6 billion in 1986. Thus, over the three years from 1984 through 1986, total savings to the federal government in the Medicare program are now estimated at more than $13 billion.

Hospitals have made an effort to compensate for these reductions by improved productivity and more efficient use of inpatient services. However, the amount of improvement that can be achieved is not unlimited. Shorter stays, more conservative use of ancillary services, greater use of home health and subacute care, and more extensive use of outpatient services all can contribute to more cost-effective medical care. However, hospital efforts to improve efficiency also may lead to higher costs for each inpatient stay because less severely ill patients increasingly receive their care outside hospitals. The sharp reduction in inpatient admissions since 1982 appears associated with faster growth of the average hospital cost-per-admission, even though total costs are now rising by less than 5 percent per year. From the perspective of the Medicare program, total expenditures have fallen substantially from projected levels. Before further cuts in payment are made, the adequacy of current payment levels must be addressed.

Hospital utilization has changed substantially since 1982. Total admissions have declined, and hospitals report significant increases in the complexity and severity of illness of patients admitted to hospitals. To some degree these changes may result in higher payments if the DRG mix of the hospital changes. However, the ability of DRGs to reflect the cost of resources used in caring for patients admitted to hospitals is limited. Particularly in small or rural hospitals, changes in utilization and cost appear to have outstripped increases in payments or revenues. Although figures for Medicare alone are not available, overall average per-case costs in hospitals operating fewer than 50 beds rose by 12.2 percent in the year ending October 31, 1985. Since this change reflects both Medicare and non-Medicare patients, the result may well have been a substantial deterioration in the financial position of smaller hospitals.

In addition, as Medicare per-case hospital payments are reduced relative to actual costs, the portion of the payment that is based on hospital-specific costs will be eliminated. The continued transition to national rates under Medicare will have a negative effect on nearly three-fifths of the hospitals that have already reported losses on their patient services. A completely national price would make it even more difficult for these institutions to regain financial soundness. These at-risk hospitals provide a significant level of the nation's Medicare services and are located in all regions of the country.

PROSPECTIVE PRICING SYSTEM ISSUES

The hospital industry supports incentives in the Medicare program which promote efficient delivery systems and cost effectiveness. The national urban and rural DRG prices established in 1983 create distortions which unjustly penalize states and hospitals within certain states while distributing these losses to states and hospitals in other states in the form of windfalls which are not related to efficiency. The adjusted gross area wage index was adopted to recognize differences paid for wages and benefits. Congress also has recognized that hospitals with high volumes of low-income patients have higher Medicare costs-per-case than other hospitals.

Congress, in the Consolidated Omnibus Budget Reconciliation Act, has called for updating the gross area wage index for prospective application and establishing a payment adjustment for hospitals with disproportionately large numbers of low-income or Medicare patients. AHA urges that this legislation be enacted as soon as possible or, failing that, Congress include these adjustments in future legislation.

CAPITAL COST REIMBURSEMENT

The Administration proposes significant reductions in Medicare payments for hospital capital costs. The budget proposal to incorporate capital payments into PPS by regulation would result in payments based on 1983 costs, which fail to adequately recognize the changes in capital costs over the past three years and the life of the transition period. The proposal would eliminate from the base year several important elements, including return on equity, interest on funded depreciation accounts, and donated assets. These adjustments erode the base year funding pool solely for budgetary reasons. The capital update factor, which would be used to project 1983 actual costs to 1987 levels, bears absolutely no relationship to the actual increase in capital costs over this period and underscores the clear intent of HHS to use this formula to reduce budget outlays. The HHS draft proposal, expected to be published in June, also contains a variety of caps on the hospital-specific portion of the payment formula restricting growth to 1986 levels. Such caps are proposed for budgetary reasons and fail to anticipate that some hospitals must increase capitalization for public health reasons.

AHA is particularly concerned that, in the current federal fiscal environment, changes in Medicare capital payment policies and methods will be used as a budget deficit reduction device, with catastrophic financial impacts on those hospitals that have recently incurred or may soon incur necessary major capital expenditures. In view of the substantial reliance of hospitals on debt sources of capital, the use of capital payment to help achieve deficit reduction goals could substantially affect investor confidence in hospital industry investments, thus unecessarily leading to an industry-wide increase in the cost of capital.

GRADUATE MEDICAL EDUCATION

The Administration's FY 1987 budget proposes major changes, to be implemented both by legislation and regulation, in the way Medicare has traditionally paid for its share of the costs of graduate medical education. The passthrough for direct medical education costs would be modified by eliminating "classroom-related expenses" for residency programs and by setting hospital-specific limits on residency expenditures. Further, the budget proposes ending Medicare support for clinical training of nurses and allied health professionals, citing as a reason that this support, as well as the payment of classroom expenses, doesn't "directly benefit Medicare beneficiaries."

The FY 1986 Administration budget had proposed freezing the direct medical education passthrough and HCFA published regulations implementing this in July, 1985, but the Consolidated Omnibus Budget Reconciliation Act overrides this provision. The conference agreement also calls for the Secretary to conduct a study by December 31, 1986 on nursing and other health professions education supported by the passthrough.

These proposed FY 87 changes in the direct medical education passthrough will not be submitted to Congress as legislation; it is expected that these policies will be implemented by regulation effective July 1, 1986, for cost reporting periods beginning on or after that date.

The indirect medical education adjustment, long recognized to be a proxy for the numerous and sophisticated ancillary patient services provided by teaching hospitals and for the severity of cases treated by these institutions, would be modified by legislation that would change the formula used in calculatiing the adjustment and would cut the adjustment in half--from the current 11.59 percent to 5.79 percent. Congress also addressed this issue in the FY 1986 reconciliation legislation, agreeing that an factor of 8.7 percent--reduced for 2 years to 8.1 percent to fund an adjustment for those hospitals that have higher Medicare costs-per-case as a result of treating a disproportionately large number of low income or elderly patients--was approporiate and justified.

The AHA opposes the Administration's indiscriminate cuts in Medicare's fair share of the costs of graduate medical education. All payers must assume a share of these costs. Hospitals that prepare physicians, nurses, and allied health professionals to take care of Medicare beneficiaries and others need adequate resources to continue to provide these services.

CONCLUSION

The Medicare program has contributed to the deficit reduction effort over the past five years with savings from the program estimated to be $45 billion by 1988. PPS hospitals have been operating under freeze since October 1984, and all hospitals payments were reduced by 1 percent as of March 1 of this year. The Adminstration's budget proposes to reduce Medicare outlays by an additional $23 billion by 1991. The proposed cuts are arbitrary, do not reflect sound health care policy, and are designed solely to reduce federal spending. If PPS is to be equitable for hospitals and beneficiaries, fair market prices must be offered for hospital Medicare services. Before further cuts in payment are made, the adequacy of current payment levels and the structure of PPS must be addressed.

Mr. Jacobs. Thank you, Jack.

Mr. O'Brien from Georgetown University. Welcome.

STATEMENT OF CHARLES M. O'BRIEN, JR., ADMINISTRATOR, GEORGETOWN UNIVERSITY HOSPITAL, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. O'Brien. Good morning, Mr. Chairman.

I am Charles O'Brien, administrator of the Georgetown University Hospital and a member of the Administrative Board of the Council of Teaching Hospitals. I appreciate this opportunity to speak with you this morning about the administration's budget proposals.

Once again the administration is proposing a budget reduction in payments to hospitals. This is especially true for the 349 non-Federal general teaching hospitals who are members of the Council of Teaching Hospitals. Ignoring changes in the DRG rates itself, Table 1 in our formal testimony presents our estimate of the three major payment reductions facing members of the Council of Teaching Hospitals. Note that: The proposed reduction for direct medical education payments is $396 million in 1987 and $3.5 billion across 5 years; the proposed reduction for the indirect medical education adjustment is $888 million in 1987 and $6.5 billion across 5 years; the proposed reduction for capital payments is $114 million in 1987 and $2.86 billion across 5 years.

Table 2 compares the reduction for the 349 Council of Teaching Hospitals' members with a reduction for all hospitals. Council of Teaching Hospitals members bear 62 percent of the reduction in the first year and 51 percent of the reduction across the 5-year period.

The most dramatic reductions are in the direct medical education passthrough and the so-called indirect medical education adjustment. For the cost of medical education programs, the administration is proposing to halt support for nursing and allied health programs and to eliminate support for the faculty who direct and supervise these activities.

The AAMC opposes both changes, hospitals with nursing and allied health programs incur costs beyond simply patient-care costs. These added costs should be recognized and supported by all payers. The AAMC also opposes the elimination of faculty support. If hospitals are to involve physicians in the training of care of patients, hospitals must provide a fully trained faculty to educate, guide and monitor the resident, the development of the resident programs. The AAMC and its council of teaching hospitals strongly recommend that this subcommittee adopt legislation to preclude the administration from making these changes by regulation. In 1985, the AAMC worked closely with this subcommittee and its staff and with your Senate counterparts to develop the proposals which would achieve significant budget savings in an equitable manner. This included (*a*) a proposal to limit the number of years of Medicare funding per resident; (*b*) a proposal to correct the formula used to pay resident-to-bed adjustment so that is curvilinear, and (*c*) a proposal to reduce the resident-to-bed adjustment to 8.7

percent. This is using the formula developed by the Congressional Budget Office.

The association still supports these changes as well as several other provisions, including a reconciliation package last year. We strongly recommend that the subcommittee return to the reconciliation provisions last year and use them in lieu of the administration's proposal.

Thank you.

[The prepared statement follows:]

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

**AAMC Positions on the
Administration's FY 1986 Budget Proposals
for Medicare**

**Presented to the Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives**

**Charles M. O'Brien, Jr.
Administrator
Georgetown University Hospital
and
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March 6, 1986

aamc

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SUMMARY OF AAMC STATEMENT

I. Impact of Administration Budget on Major Teaching Hospitals

- A. The proposed reduction for direct medical education payments is $396 million in 1987 and $3.54 billion across five years.
- B. The proposed reduction for the indirect medical education adjustment is $888 million in 1987 and $6.5 billion across five years.
- C. The proposed reduction for capital payments is $114 million in 1987 and $2.864 billion across five years.
- D. 349 COTH members bear 62% of the reduction in the first year and 51% of the reduction across five years.

II. AAMC Recommendations

- A. Direct Medical Education Costs
  1. The AAMC supports retaining explicit Medicare funding of graduate medical education for at least the number of years required to attain board eligibility in various specialties (to a maximum of five years) plus one additional clinical year for advanced specialty and subspecialty positions in hospitals in which the positions were supported by Medicare in FY 1984-85.
  2. The AAMC supports eliminating Medicare funding for residents who are not graduates of accredited medical (or osteopathic) schools located in the United States or Canada.
  3. The AAMC supports a phase-in of Medicare payment changes for any foreign medical graduate presently in a residency and for any resident presently in a specialty which would not be included in the passthrough so that these residents and fellows are allowed to complete their training.
- B. The Indirect Medical Education Adjustment
  1. The AAMC supports recomputing the resident-to-bed adjustment using current hospital resident and bed data, up-to-date corrected hospital case mix indices, and a regression equation which incorporates only variables used in determining DRG payments. The most recent analyses by the Congressional Budget Office support a curvilinear adjustment of 8.7% per 0.1 resident per bed.
  2. The AAMC strongly supports including the same types of residents in the payout of the indirect medical education adjustment as are included in the statistical formulation of the adjustment.
- C. DRG Pricing
  1. The AAMC strongly recommends that Congress amend the Prospective Payment System so that payments are based on a DRG specific, blended rate of hospital-specific and federal component prices.

2. If Congress is unwilling to enact DRG specific price blending, then the AAMC recommends that Congress amend the DRG price formula so that it is based on 50% hospital-specific costs and 50% regional average costs.

3. The AAMC recommends that the current pause in the phase-in of national prices be continued throughout 1986 and that the FY1987 price be based on at least a hospital-specific component of 25%.

4. The AAMC supports increasing DRG prices for 1987 by the market basket plus 0.25% which is the formula in the statute.

D. Payments for Hospital Capital--See testimony of February 24, 1986

E. Disproportionate Share Providers

   1. The AAMC supports establishing an adjustment in prospective payments to recognize the generally higher costs incurred by hospitals serving a disproportionate number of indigent Medicare patients. The AAMC recognizes that implementation of a disproportionate share adjustment may lead to a recalculation of the percentage used for the indirect medical education adjustment.

F. Physician Fees

   1. The AAMC opposes any extension of the Medicare freeze on payments to physicians for professional medical services and urges Congress to mandate retaining the present methodology for calculating the Medicare economic index.

The Association of American Medical Colleges which represents all of the nation's medical schools, 82 academic societies, and over 350 major teaching hospitals participating in the Medicare program, welcomes the opportunity to testify on the Administration's Fiscal Year 1987 budget proposals for Medicare.

Once again this year, the Reagan Administration is using the Federal budget process to propose major changes in hospital and physician payments for services to Medicare patients. Six of their proposals are of significant concern to teaching hospitals and their physicians:

- o the proposed reduction in payments in direct medical education,
- o the proposed reduction to 5.79% for the indirect medical education adjustment in spite of an extensive CBO analysis supporting a reduction to only 8.7%.
- o the proposed implementation of DRG payments at 100% national rates and 0% hospital-specific rates effective October 1, 1987,
- o the proposed 2% increase in DRG prices which results essentially in a freeze at 1985 payment levels if the reduction under Gramm-Rudman-Hollings goes into effect,
- o the proposed implementation of a new, highly restrictive capital payment policy by regulation, and
- o the proposed retroactive recalculation of the Medicare economic index in order to reduce fee payments for prevailing physician fees.

Each of these proposed changes would result in a substantial reduction in Medicare revenues for teaching hospitals and their medical staffs. Ignoring changes in the DRG rate itself, Table 1 presents the AAMC's estimate of the three major payment reductions facing members of the Council of Teaching Hospitals:

- the proposed reduction for direct medical education payments is $396 million in 1987 and $3.54 billion across five years,
- the proposed reduction for the indirect medical education adjustment is $888 million in 1987 and $6.5 billion across five years, and
- the proposed reduction for capital payments is $114 million in 1987 and $2.864 billion across five years.

Table 2 compares the reduction for the 349 COTH members with the reduction for all hospitals. COTH members bear 62% of the reduction in the first year and 51% of the reduction across five years. As a result, the financial stability of many of the nation's teaching hospitals may be seriously weakened. Therefore, the Association of American Medical Colleges is compelled to speak out on the Administration's proposals and also to raise the issue of an adjustment for "disproportionate share" hospitals.

Direct Medical Education Costs

To provide clinical training for residents, nurses, and allied health personnel, hospitals incur costs beyond those necessary for patient care. Since its inception, Medicare has paid its share of these added direct expenses on a cost reimbursement basis. Under prospective payment, cost reimbursement for these expenses is continued using the "direct medical education passthrough."

Table 1

Dollar Reduction in COTH Hospital Revenues Under Administration Proposals, FY 1987

		Council of Teaching Hospital Reductions			
Fiscal Year	Total Hospital Payment Reduction* (in Millions)	Direct Medical Education	Indirect Medical Education Adjustment	Capital Payments	Total COTH Reduction (in Millions)
1987	$ 2,268	$ 396	$ 888	$ 114	$ 1,398
1988	3,753	528	1,212	359	2,099
1989	4,919	644	1,336	570	2,550
1990	6,132	768	1,456	796	3,020
1991	7,780	908	1,596	1,025	3,529
TOTAL	$24,852	$3,254	$6,504	$2,864	$12,596

*Total Hospital payment reductions include hospital capital payments, direct medical education payments, indirect medical education payments, return on equity, waiver of liability, and malpractice.

Assumptions: Hospitals in COTH admit approximately 25% of all Medicare admissions to short-term, non-Federal hospitals. Estimate assumes these hospitals receive 35% of capital payments. Estimate assumes COTH hospitals receive 80% of direct medical education payments and 80% of indirect medical education adjustment.

Table 2

COTH Reductions Under Administration Proposals, FY 1987

		COTH Payment Reductions		
Fiscal Year	Total Hospital Payment Reduction* (in Millions)	COTH Payment Reduction (in Millions)	COTH as Percentage of Total	Reduction Per COTH Hospital
1987	$ 2,268	$ 1,398	62%	$ 4.0 million
1988	3,753	2,099	56	6.0 million
1989	4,919	2,550	52	7.3 million
1990	6,132	3,020	49	8.7 million
1991	7,780	3,529	45	10.1 million
TOTAL	$24,852	$12,596	51%	$36.1 million

*Total Hospital payment reductions include hospital capital payments, direct medical education payments, indirect medical education payments, return on equity, waiver of liability, and malpractice.

Assumptions: Hospitals in COTH admit approximately 25% of all Medicare admissions to short-term, non-Federal hospitals. Estimate assumes these hospitals receive 35% of capital payments. Estimate assumes COTH hospitals receive 80% of direct medical education payments and 80% of indirect medical education adjustment.

Medicare's share of the direct medical education passthrough is determined using generally accepted accounting principles and Medicare reimbursement regulations. The hospital accounting system accumulates expenses directly associated with these activities in specific cost centers. For example, hospital expenses for resident stipends are recorded in the graduate medical education (or intern and resident) cost center. After all expenses are entered, overhead expenses -- such as administration, maintenance, and utilities -- are allocated (or apportioned) across the Medicare cost centers such as graduate medical education. Thus, the cost being reimbursed through the direct medical education payment includes expenses incurred by the cost center and allocated overhead.

In its 1987 budget, the Administration proposes three major changes in the Medicare passthrough for direct medical education costs. First, educational costs included in residency training would be eliminated. While detailed language is not available yet, informal discussions with staff at HHS suggest the Health Care Financing Administration will propose that expenses for faculty salaries, faculty benefits and faculty support costs be eliminated from the passthrough. Second, the budget proposes "hospital-specific" limits on interns and resident' salaries. HHS staff indicate hospitals will be required to compute an allowable cost per resident including stipends, benefits and allocated overhead. Future year costs per resident would be limited to costs per resident in the base year adjusted for inflation. Third, expenses for nursing and allied health programs would be eliminated as allowable costs in the passthrough.

The AAMC believes each of these changes is ill-advised. As the Department of Health and Human Services stated in the Secretary's 1982 report Hospital Prospective Payment for Medicare (pp 47-48):

> The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.

In 1983, Congress supported the Department's position that it was not appropriate to include clinical training costs in the DRG payment and approved continuing to pay the costs of graduate medical education on a cost reimbursement basis separate from the DRG based per case payment. This policy is as valid in 1986 as it was in 1983.

Hospitals providing our nation with health manpower education in addition to patient services need additional revenues beyond patient care payments to support the added responsibilities. It is inappropriate to pretend that residency programs can be operated without faculty to train and supervise residents. It is equally inappropriate to ignore the costs of nursing and allied health education programs.

Last year, this Subcommittee carefully examined Medicare payments for direct medical education. The AAMC worked cooperatively and openly with the Subcommittee and its staff. The Association believes the proposals developed in Congress last year are more appropriate than those proposed by the Administration in its 1987 budget. Therefore,

- THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS RETAINING EXPLICIT MEDICARE FUNDING OF GRADUATE MEDICAL EDUCATION FOR AT LEAST THE NUMBER OF YEARS REQUIRED TO ATTAIN BOARD ELIGIBILITY IN VARIOUS SPECIALTIES (TO A MAXIMUM OF FIVE YEARS) PLUS ONE ADDITIONAL CLINICAL YEAR FOR ADVANCED SPECIALTY AND SUBSPECIALTY POSITIONS IN

HOSPITALS IN WHICH THE POSITIONS WERE SUPPORTED BY MEDICARE IN FY 1984-85.

- THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS ELIMINATING MEDICARE FUNDING FOR RESIDENTS WHO ARE NOT GRADUATES OF ACCREDITED MEDICAL (OR OSTEOPATHIC) SCHOOLS LOCATED IN THE UNITED STATES OR CANADA.
- THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS A PHASE-IN OF MEDICARE PAYMENT CHANGES FOR ANY FOREIGN MEDICAL GRADUATE PRESENTLY IN A RESIDENCY AND FOR ANY RESIDENT PRESENTLY IN A SPECIALTY WHICH WOULD NOT BE INCLUDED IN THE PASSTHROUGH SO THAT THESE RESIDENTS AND FELLOWS ARE ALLOWED TO COMPLETE THEIR TRAINING.

The Indirect Medical Education Adjustment

When prospective payment was being considered, the Congressional Budget Office testified before this Subcommittee and compared the system's impact on teaching and non-teaching hospitals. CBO's February, 1983 assessment showed that 71% of teaching hospitals would lose money compared with TEFRA, while only 32% of non-teaching hospitals would lose money. It should be noted that this impact assessment assumed the original resident-to-bed adjustment of approximately six percent.

Why would teaching hospitals do poorly? Four factors contribute heavily to this adverse impact. First, when HCFA set the regional and national average prices, they computed the average on a hospital-weighted, rather than a case weighted, basis. Therefore, in computing the average, a major teaching hospital admitting 10,000 Medicare cases had the same impact as a small suburban hospital with 750 Medicare admissions. The effect of the use of a hospital-weighted average is that the "price norm" (i.e., average price) for urban hospitals is a 255 bed hospital. In the Council of Teaching Hospitals, the average hospital has 562 beds. The scope of services and therefore average costs of a hospital generally vary with bed size. This was recognized in the TEFRA limits where hospitals were compared using bed size groups. Under TEFRA, larger hospitals had higher limits. HCFA's use of an approach for prospective payments that sets prices approximating the costs of a 255 bed hospital hurt teaching hospitals. Secondly, the DRGs have only 468 categories for recognizing differences between patients. If each hospital received an equal variety of patients in each DRG, 468 categories would not cause serious problems. Teaching hospitals do not receive a random mix of patients. Teaching hospitals receive the sickest, most difficult and most costly cases. Without such an adjustment, teaching hospitals are hurt by an average pricing system. Unfortunately, no easily implemented system to adjust the DRG for the difference in patient severity was available in 1983 and none is yet available. Thirdly, hospitals in large metropolitan areas have higher average costs than those in smaller cities, and central city hospitals have higher average costs than suburban hospitals. These costs include differences such as increased security and social service departments. Teaching hospitals are heavily concentrated in the central cities of major metropolitan areas. Because the prospective payment system does not adjust for the higher costs of central cities, teaching hospitals are hurt by the average pricing system of prospective payments. Finally, when HCFA estimated the factor for the resident-to-bed adjustment, they included two variables in the analysis -- hospital bed size and urban area size -- which were not included in the payment system. As a result, the computed adjustment was understated and teaching hospitals were adversely impacted until Congress doubled the computed adjustment.

Thus, while the resident-to-bed adjustment is called the "indirect adjustment for cost accompanying medical education," it is, in fact, a proxy measure to provide appropriate compensation for the added patient service costs borne by teaching hospitals. It helps correct for the fact that too few variables are used to set prices in the current system. Nevertheless, its "medical education" label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in cost between teaching and non-teaching hospitals. The AAMC is concerned about this misperception.

Last year, the AAMC worked with this Subcommittee, its Senate counterpart, and analysts from the Congressional Budget Office to re-estimate a statistically appropriate percentage for the resident-to-bed adjustment. The Association has reviewed the CBO analysis and concluded the study was properly conducted. Therefore,

- o THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS RECOMPUTING THE RESIDENT-TO-BED ADJUSTMENT USING CURRENT HOSPITAL RESIDENT AND BED DATA, UP-TO-DATE CORRECTED HOSPITAL CASE MIX INDICES, CORRECTED WAGE INDICES, AND A REGRESSION EQUATION WHICH INCORPORATES ONLY VARIABLES USED IN DETERMINING DRG PAYMENTS. THE MOST RECENT ANALYSES BY THE CONGRESSIONAL BUDGET OFFICE SUPPORT A CURVILINEAR ADJUSTMENT OF 8.7% PER 0.1 RESIDENT PER BED.

In last year's prospective payment regulations, HCFA proposed excluding residents assigned to outpatient settings from the resident-to-bed ratio. As the Prospective Payment Assessment Committee has stated, this change is inappropriate because residents in both inpatient and outpataient settings were used in computing the adjustment. HCFA has ignored ProPAC, AAMC and other objections and finalized the regulations to exclude outpatient residents. The regulations are not in effect, however, because of the Congressional extension continuing September 30 reimbursement practices. Last year, the reconciliation bill included both House and Senate provisions to require HCFA to continue including in the resident-to-bed ratio the same types of residents used to compute the adjustment. The AAMC requests that this provision be included in the actions of this Subcommittee.

- o THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES STRONGLY SUPPORTS INCLUDING THE SAME TYPES OF RESIDENTS IN THE PAYOUT OF THE INDIRECT MEDICAL EDUCATION ADJUSTMENT AS ARE INCLUDED IN THE STATISTICAL FORMULATION OF THE ADJUSTMENT.

DRG Pricing

In enacting the prospective payment system, Congress wisely included a phased transition so (1) that the hospital-specific payment component would provide hospitals with some protection against inherent weaknesses in the system and (2) that policy could be changed before the weaknesses caused major damage. Those weaknesses are already coming to light: HCFA's data show that many DRGs include patients with highly varying costs while other DRGs have a relatively small variation in costs, geographic regions have consistent but poorly understood differences in hospital operating costs, and "dumping" of economically undesirable Medicare patients is on the increase. To minimize the adverse impacts of these weaknesses while providing hospitals with an incentive for efficiency, the AAMC strongly recommends replacing the original price blending formulas with a new approach which blends a hospital-specific price component and a Federal average price component using the observed variation in DRG costs. Where data show hospitals care for patients in a given DRG at relatively consistent costs, the DRG payment would depend heavily on the Federal price component. On the other hand, where data show hospital costs for patients in a given DRG vary widely, the DRG payment would be based significantly on the hospital-specific price component.

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES STRONGLY RECOMMENDS THAT CONGRESS AMEND THE PROSPECTIVE PAYMENT SYSTEM SO THAT PAYMENTS ARE BASED ON A DRG SPECIFIC, BLENDED RATE OF HOSPITAL-SPECIFIC AND FEDERAL COMPONENT PRICES.

While the AAMC realizes there is little support for the blended rate proposed, the Association still believes it is an appropriate long-range solution. An alternative interim approach that would moderate both "windfalls" and catastrophes would be to set payments based on a blend of hospital-specific and average prices. A 50/50 blend would provide both strong economic incentives for improved management and an economic safety net against shortcomings in the initially enacted system.

For the Federal component, the regional average should be retained. At the present time, it is not clear why urban hospitals in New England, the Great Lakes, the Northern plains, and the Pacific states have costs above the national average. Absent an understanding of the higher costs in the regions and with no clear evidence that hospitals in these four regions are less efficient than those in the other five regions, it seems premature to move to prices set using the national average. Therefore,

> IF CONGRESS IS UNWILLING TO ENACT DRG SPECIFIC PRICE BLENDING, THEN THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT CONGRESS AMEND THE DRG PRICE FORMULA SO THAT IT IS BASED ON 50% HOSPITAL-SPECIFIC COSTS AND 50% REGIONAL AVERAGE COSTS.

The Administration's budget gives no recognition to the problems resulting from the rapid move to a single national price for determining DRG payments. The budget also provides no recognition of the pause in the transition that has occcurred in fiscal year 1986. Instead, the Administration's budget assumes that DRG prices on October 1, 1986 will be based 100% on national prices with no role for either regional or hospital-specific prices. Such a rapid move to 100% national prices would heighten the problems the present pause was intended to address. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THE CURRENT PAUSE IN THE PHASE IN OF NATIONAL PRICES BE CONTINUED THROUGHOUT 1986 AND THAT THE FY 1987 PRICE BE BASED ON AT LEAST A HOSPITAL-SPECIFIC COMPONENT OF 25%.

For DRG prices, the Administration's budget suggests a "tentative" increase of 2% for 1987. This would follow a price freeze for 1986. Moreover, if the Gramm-Rudman-Hollings reductions are imposed, the "tentative" 2% increase would be accompanied by a 2% decrease in payments. This would result in payments for care provided in 1987 at 1985 prices. In an economy that is still experiencing significant inflation, the AAMC believes hospital payments should not be effectively frozen at 1985 prices. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS INCREASING DRG PRICES FOR 1987 BY THE MARKET BASKET PLUS 0.25% WHICH IS THE FORMULA IN THE STATUTE.

Payments for Hospital Capital

The budget proposes using regulation, rather than legislation to include capital costs in DRG payments. A four year phase-out of hospital-specific capital is proposed. The proposal would dramatically reduce capital payments because the Federal component is based on 1983 data updated inadequately for recent capital spending and by the requirement that interest earned on funded depreciation be used to reduce interest paid on capital loans. The hospital-specific component would be the lesser of actual costs or a 1986 base period adjusted by the increase allowed in DRG prices. The hospital-specific calculation would have to phase-in the interest offset on funded depreciation across three years.

Last week, the AAMC submitted a statement on "Medicare Payments for Hospital Capital" to this Subcommittee. The Association continues to oppose implementing a new capital payment policy by regulation, objects to a four year phase-in, and recommends that any percentage phase-in of capital costs recognize current costs for any hospital-specific component and up-to-date costs for any Federal component.

Disproportionate Share Providers

While the Administration's budget once again chooses to ignore the issue, hospitals serving a disproportionate share of the poor face significant problems. Within a DRG, low income patients tend to use more services than non-indigent patients. This often results from waiting longer to seek medical care, or because of chronic illnesses and complicating conditions, or from the absence of a suitable home environment to which the patient can be discharged. Hospitals serving these patients also provide more support services ranging from medical social workers to interpreters. Thus, low income Medicare patients tend to be more costly than non-indigent Medicare patients. While the Administration once again chooses to ignore these costs, they should be recognized in the prospective payment system. Therefore, THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS ESTABLISHING AN ADJUSTMENT IN PROSPECTIVE PAYMENTS TO RECOGNIZE THE GENERALLY HIGHER COSTS INCURRED BY HOSPITALS SERVING A DISPROPORTIONATE NUMBER OF INDIGENT MEDICARE PATIENTS. THE AAMC RECOGNIZES THAT IMPLEMENTATION OF A DISPROPORTIONATE SHARE ADJUSTMENT MAY LEAD TO A RECALCULATION OF THE PERCENTAGE USED FOR THE INDIRECT MEDICAL EDUCATION ADJUSTMENT.

Physician Fees

Fees paid by Medicare for physicians' professional medical services have been frozen since July 1, 1984. No recognition in Medicare payments has been included for either mandatory increases, like Social Security taxes, or uncontrollable expenses, like professional liability premiums. In fact, on March 1, Medicare payments to physicians were decreased by 1%.

While the Administration's budget appears to provide an end to the freeze on physician fees, the change is more in appearance than fact. This occurs because the budget proposes to recalculate the Medicare economic index which limits prevailing fees. The index, which has been used for more than a decade, would be revised retroactively using a new housing cost component. As a result, prevailing fee limits would go up only a little or perhaps decline. The AAMC believes this change is an inappropriate effort to retain most of the impact of a fee freeze with little of its political liability. In this situation,

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES OPPOSES ANY EXTENSION OF THE MEDICARE FREEZE ON PAYMENTS TO PHYSICIANS FOR PROFESSIONAL MEDICAL SERVICES AND URGES CONGRESS TO

MANDATE RETAINING THE PRESENT METHODOLOGY FOR CALCULATING THE MEDICARE ECONOMIC INDEX.

Conclusion

Teaching hospitals are a diverse group of highly complex institutions performing medical education and research for the nation and providing both basic and tertiary patient care. The current emphasis on re-examining national policies in light of more limited public resources places teaching hospitals and their vital activities at significant risk if their special nature and role are not supported. As policies and expectations change, teaching hospitals will continue to adapt and evolve. If national policies on health care delivery and payment recognize the distinctive characteristics and diversity of teaching hospitals, their fundamental missions can be preserved. If the characteristics of teaching hospitals are not recognized and valued, simplistic public policies may damage the ability of these institutions to fulfill their responsibilities.

If the Medicare prospective payment system is to provide hospitals with an appropriate incentive for efficiency, methodological weaknesses must be eliminated, inaccurate data must be corrected, and real differences in the cost of various types of hospitals should be recognized. The AAMC recommendations have been developed to provide a more reasonable and equitable prospective payment system than that recommended in the Administration's budget proposal.

Finally, to preserve physician interest in caring for Medicare patients, physician services must be reasonably compensated. The existing almost two year freeze is unreasonable. Any extension of the freeze or change to reduce the Medicare economic index is inappropriate. Physician fees should be updated using present methodologies and payment approaches.

Mr. JACOBS. Thank you, Dr. Freedman.

STATEMENT OF JANET FREEDMAN, M.D., OFFICER AT LARGE, COMMITTEE OF INTERNS AND RESIDENTS, NATIONAL FEDERATION OF HOUSESTAFF ORGANIZATIONS

Dr. **FREEDMAN**. Thank you. My name is Janet Freedman. I am a resident physician at Bellevue Hospital in New York City. I am speaking today on behalf of the National Federation of Housestaff Organizations, which represents the largest number of organized interns and residents in the United States.

I will address today the issue of the elimination of direct payments and decrease of indirect payments for graduate medical education as proposed in the President's budget.

We believe these cuts will severely reduce the availability and the quality of health care to the growing number of medically indigent and Medicare population as well as jeopardize the training of new physicians.

Interns and residents, also called housestaff or house officers, have completed medical school and received their M.D.—doctor of medicine—degree. Residents then work in the Nation's teaching hospitals providing hands-on patient care while simultaneously completing 3 to 7 years of specialty training. These are the years referred to as graduate medical education.

Residents now work disproportionately in the public hospitals and, as a result, we are the primary physicians for the medically underserved of this country. The public policy served by the funding of graduate medical education, therefore, not only ensures the continued production of well-trained physicians but perhaps more importantly, provides health care services to the medically indigent Medicare/Medicaid population.

Given this dual function of graduate medical education, it is entirely appropriate for Federal funding to continue. Congress now acknowledges the special societal role of teaching hospitals in its allocation of indirect and direct payments for residency programs. Likewise, it is entirely appropriate that patient care revenues including Medicare be utilized for graduate medical education, given that direct patient care services make up the bulk of a resident's work.

In addition to providing the health care for the under served, housestaff provide that care in the most cost-effective manner, as we work extraordinarily long hours for relatively little money. Should residency programs be reduced or eliminated, that same care would need to be provided either by more costly physicians or by nonphysician providers.

It is the Government's responsibility, we believe, to determine society's health care needs and set policy priorities for medical manpower. To the extent there will be changes in Federal funding for health care including graduate medical education, Congress should now further distinguish and set funding priorities for specific teaching hospitals and specific specialties.

We believe Congress should target funding both direct and indirect toward residency programs in those teaching hospitals and clinics which serve a disproportionate share of low-income patients.

This will enable such programs to attract the most qualified medical students as well as assist these financially burdened hospitals to deliver quality care.

Similarly, funding should target those programs which train primary care physicians as well as other identified specialties now in shortage or with a projected shortage. In addition, funding should target residencies which recruit and train minority physicians, as minority physicians have been shown to be more likely to continue to provide care to the underserved.

Reciprocally, programs in hospitals which fail to meet public policy objectives should be defunded and private hospitals which dump medically indigent patients on public hospitals should be financially penalized.

In summary, the National Federation of Housestaff Organizations believes elimination of direct payment and decreasing indirect payment for graduate medical education will harm both physician training and health care services for the already underserved segment of the population.

It is our position that it is the role of Congress to continue funding of graduate medical education through patient revenue sources and further, to target areas of need to receive such funding as an incentive to improve the quality of care to the underserved, train minority physicians and encourage training in primary care and other shortage specialties.

Thank you.

[The prepared statement follows:]

STATEMENT OF JANET FREEDMAN, M.D., NATIONAL FEDERATION OF HOUSESTAFF ORGANIZATIONS

The attachment summary and proposals of the National Federation of Housestaff Organizations, representing the largest number of organized interns and residents in the United States, speak directly to the funding of direct and indirect payments for "graduate medical education." The President's proposals to eliminate direct payments, decrease indirect payments and to phase out funding for positions held by FMGs will severely reduce the availability and quality of health care to the growing number of medically indigent and Medicare/Medicaid population. The system by which our nation's doctors get trained and our nation's poor get medical care needs reforming, not dismantling.

SUMMARY

The public policy served by monies spent on "Graduate Medical Education" is not only to ensure the production of well-trained physicians, but more importantly, to provide health care services in the least costly manner to the Medicare/Medicaid and medically indigent population. This has been a well-known, if often unstated, premise of public "GME" funding.

To the extent that there will be changes in federal funding for healthcare and thus for all of its components, including "GME", this underlying policy must be clear both for the sake of patient care and in order to achieve true dollar savings.

Funding for "GME" should continue; patient care revenues should be the principal source of funding; and that funding should be better directed by Congress to achieve clearly articulated public policy goals.

Specific proposals include targeted funding for residency programs which: (1) serve a disproportionate number of low-income patients; (2) train physicians specializing in primary care and fields of existing and projected medical need; and (3) train minority physicians who are known to be more likely to practice in medically underserved areas.

Reciprocally, programs in hospitals which fail to meet public policy objectives should be defunded.

Quality of medical school graduates is best controlled by other means than withholding funds.

WHO SETS POLICY?

It is the government's responsibility to determine society's healthcare needs and to set policy priorities at least insofar as the government funds and regulates healthcare. Two interrelated and essential societal needs are met by residency programs in teaching hospitals: the training of doctors and medical care for patients, in particular, care for low-income patients.

WHAT SHOULD BE THE SOURCES OF FUNDING?

Federal funding for residency programs is entirely appropriate given its purpose. Residents, also known as housestaff, work long hours for relatively little money. They provide the bulk of medical care in most teaching hospitals on a very cost-efficient basis. That is, should residency programs be reduced or eliminated, the services would have to be produced by other more costly combinations of provider services. Furthermore, senior residents provide much of the training to incoming residents.

Patient care revenues, including Medicare and Medicaid, are entirely appropriate funding sources given the patient care services provided by residents. However, investigating the possibility of additional governmental funding sources is indicated.

HOW SHOULD THE FUNDING BE DISTRIBUTED?

Congress already acknowledges the special societal functions of teaching hospitals as compared to non-teaching hospitals in its allocation of indirect and direct payments for residency programs. Congress should further distinguish and set funding priorities for specific teaching hospitals and specific specialities. (The methodology, formulas and definitions need be, and certainly can be, further elaborated.)

Congress should target funding—both direct and indirect, by means of incentives and disincentives—to residency programs in teaching hospitals and their corresponding clinics which serve a disproportionate share of low-income patients. Purposes: (1) Directors of programs in these institutions will have resources to improve the quality of their programs; (2) these programs, which currently do not attract the most qualified medical school graduates, will be more able to do so; and (3) it will provide additional resources to these financially burdened hospitals.

Congress should target funding—both direct and indirect, by means of incentives and disincentives—for residency programs in primary care specialities and those fields with existing and projected medical need. Congressman Waxman's HR2699 of last session provides a structural framework, but needs further refinement. Each speciality must be studied in regards to its projected manpower "surplus or deficit" its speciality requirements and its function as "primary" or "non-primary". Open hearings should be held to bring out the complexities of this issue and thus enable Congress to develop a rational health manpower policy for medicine, or, at minimum, to give clear direction to the Secretary of Health and Human Services in studies undertaken and councils formed. Purpose: It sets the principle of the priority of primary care medical services which is both medically and economically sound.

Target funding—both direct and indirect, by means of incentives and disincentives—for those residency programs with active affirmative action policies, which recruit underrepresented minority medical school graduates. The standards by which funding formulas are derived should be regionally-based to reflect the composition of the population in the region. Purposes: (1) To reverse the trend of declining minority applications, acceptances and enrollments into medical schools; and (2) as minority doctors are more likely to provide care to minority patients, this will serve to increase the number of medical school graduates attracted to residency programs which serve a disproportionate number of low-income patients, who are disproportionately minority. It will serve to improve access to medical care for minority Americans.

HOW SHOULD THE QUALITY OF MEDICAL SCHOOL GRADUATES BE CONTROLLED?

Control the quality of medical school graduates by encouraging the establishment of one standarized examination to be taken by graduates of all medical schools no matter where they are located. All medical school graduates, having passed this examination, should be counted identically for purposes of funding.

ADDITIONAL FUNDING FOR HOSPITALS SERVING LOW-INCOME PATIENTS

Congress should establish a mechanism to ensure that the Secretary of Health and Human Services enforces the current disproportionate share adjustment.

Private hospitals which "dump" medically indigent patients on public hospitals should be financially penalized. Those public hospitals receiving these patients should receive this financial compensation.

Mr. JACOBS. Dr. Freedman, thank you very much.

Nurse Powell.

STATEMENT OF NANCY MacKENZIE POWELL, R.N., VICE PRESIDENT, GOOD SAMARITAN HOSPITAL, NATIONAL LEAGUE FOR NURSING, ACCOMPANIED BY SALLY SOLOMON

Ms. POWELL. Mr. Chairman, thank you for the opportunity to speak. I am Nancy MacKenzie Powell, vice president of Good Samaritan Hospital in Cincinnati, Ohio. Today I am speaking on behalf of the National League for Nursing, which is the official accrediting agency for nursing education and represents approximately 2,000 agencies and 15,000 individuals dedicated to improving the quality of health care through nursing education. As the vice president of the Good Samaritan Hospital, my responsibilities include a diploma school of nursing, nursing service, risk management, medical records, ambulatory services, social services, and a long-term care facility. With me today is Ms. Sally Solomon from the National League for Nursing.

Our testimony addresses the administration's 1987 budget proposal to eliminate the Medicare passthrough for nursing education. The NLN opposes the elimination of this funding because of the impact it would have on nursing education programs and on the collaborative arrangements between hospitals and schools of nursing for the clinical placement of nursing students, arrangements that enhance the care that Medicare beneficiaries receive in hospitals with these clinical education programs.

We urge the committee to reject the administration's proposal and to support a more thorough examination of Medicare support for clinical education as the basis for future policy revisions.

As the committee knows, the Medicare Program has supported clinical education for nursing, medicine and allied health professions since its inception. Medicare adopted this policy on the premise that students in these clinical education programs provided patient care services. This premise is still valid. Furthermore, Medicare recognized that as a purchaser of hospital services it shared the responsibility for supporting the education of students who would be the next generation of health care professionals.

Clinical placement experiences are an essential component in all nursing curriculum and are part of the NLN's accreditation standards for all nursing education programs, practical nurse diploma, baccalaureate and graduate nursing education. For each of these types of programs, there are clinical rotations arranged with hospitals for the students' clinical experiences. For these experiences, student nurses under joint hospital staff and nursing school faculty supervision, provide a variety of patient care services.

In a number of conversations with HCFA, we have learned that present hospital cost reporting practices make it difficult to quantify the full extent of financial support from Medicare for nursing education. First, the data are several years old and may not reflect the current amount or distribution of these funds. Second, these data do not identify the various types of arrangements between hospitals and nursing educational programs. This information is essential for an accurate accounting of the flow of Medicare funds for nursing education.

What we do know is that because of stipulations in the Medicare law, most of the money is allocated for nursing education programs that are operated directly by providers. Each hospital identifies its costs for hosting these programs and claims reimbursement from Medicare for its proportionate share.

At this point I would like to speak to our own nursing education program for which 36 percent of our direct medical education reimbursement goes to support 40 percent of the School of Nursing's costs. In 1985, the total cost of the Good Samaritan Hospital School of Nursing was $2,659,000.

If this reimbursement were reduced, it would mean that the hospital would have to make a policy decision relative to the education of nurses. That would be because of a 60-percent requirement for increase in tuition to meet the reduction in the Medicare reimbursement. The fact that financial aid for nurse's education is also scheduled for reduction would compromise our education program even further.

The clinical placement of students is seen as essential to the schools from an educational and learning perspective, in order to prepare competent practitioners. It also facilitates nurse retention and recruitment. It helps provide patient care and it provides innovation in nursing care in response to changing demand.

In our own school of nursing, which we have 247 enrolled, the average student is 19 years old, a white female, from a blue collar family with less than $25,000 income annually. Seventy-two percent of our students receive some form of financial aid. The reduction in, or worse, elimination of the Medicare reimbursement that now benefits nursing education would further reduce opportunities for these students to become contributing members of society through the nursing education program.

Mr. Chairman, as you know, the administration's 1987 budget proposal includes total elimination of Medicare financial support for the clinical education of nursing and allied health professions. These changes would be implemented through regulations without any congressional mandate.

The NLN strongly believes that it is inappropriate and unwise to make changes in the present policy without direction from Congress.

Elimination of the current passthrough for nursing clinical education could threaten the viability of many nursing education programs and interfere with patient care services. Many hospitals would be left with fewer vital nursing resources.

In a Greater Cincinnati hospital council hospital manpower study of 1984, 50 percent of the hospitals surveyed indicated that although some positions in nursing are relatively easy to fill, they have significant difficulty filling critical care nursing positions. Also, 38 percent of the hospitals surveyed said that in 1990, they anticipate significant difficulty in recruiting for all nursing positions because of other changes in society, such as declining pool of persons entering nursing and the greater number of career choices for women.

In our aging population, there is both a component of acute and chronic care. Even though average lengths of stays and occupancies are declining, the intensity of services is like a bell shape curve which has had both ends chopped off. That is what is happening to those patients who are in acute care settings. More is happening in less time to more acutely ill patients and with nearly everything that is happening, there is a nursing component attached to it.

Furthermore, hospital administrators in many geographic areas are reporting nursing shortages and difficulties in recruiting nurses. We wholeheartedly support the provision in the 1985 reconciliation bill, H.R. 3128, whereby Congress directed the Department to conduct a study on the nursing education activities, reimbursable under Medicare. The further reconciliation of this bill is still pending.

We urge your committee to endorse this study and take whatever steps are necessary to promote its implementation as soon as possible. In that way, Congress and the administration can formulate a rational and timely policy regarding nursing education support under Medicare.

We believe that it is premature to eliminate Federal funding for nursing education under Medicare until all key players, Congress, the administration, nurse educators and hospital administrators, have a more precise picture of the flow of these funds.

To summarize, we further believe it is inequitable to eliminate Medicare funding for nursing education while continuing similar support for clinical education in medicine. We recognize the differences between the allocation of funds for graduate medical education and nursing clinical education. We know that nursing students do not receive stipends such as medical interns and residents. However, without more accurate costing out of the costs and benefits to hospitals and schools for the clinical placement of nurses, it would be short-sighted to wipe out these funds altogether.

Mr. Chairman, a sense of urgency compounds the picture, because of the administration's intent to issue proposed regulations this month, that would implement its budget proposal. The NLN strongly urges this committee to call on the administration to postpone these regulations until completion of the study included in H.R. 3128.

In summary, the NLN recommends that Congress promptly enact the provision in H.R. 3128 to study nursing education activities reimbursable under Medicare and Congress direct the administration to postpone its proposed regulatory initiative to eliminate Medicare support of nursing education.

Mr. Chairman, I thank you for the opportunity to present testimony and I am willing to answer any questions.

[The prepared statement follows:]

Statement of Nancy MacKenzie Powell, R.N., B.S., Vice President, Good Samaritan Hosptial, on Behalf of the National League for Nursing March 6, 1986

SUMMARY

The Administration announced its intention to eliminate the Medicare pass-through for nursing education through a regulatory initiative. NLN opposes the elimination of this funding for the following reasons: (a) Nursing students make significant contributions in caring for Medicare beneficiaries in hospital settings. (b) It is inconsistent to eliminate altogether Medicare funding for clinical nursing education while continuing similar support for clinical education in medicine.

In our testimony, we have provided the background and rationale for Medicare's policy which, since its inception, has supported clinical education for nursing, medicine and allied health professions.

The NLN recommends that: (a) Congress promptly enact the provision in H.R. 3128 to study nursing education activities reimbursable under Medicare. (b) Congress direct the administration to postpone its proposed regulatory initiative to eliminate Medicare support of nursing education.

STATEMENT

Mr. Chairman, I am Nancy MacKenzie Powell, BS, RN, Vice-President of Good Samaritan Hosptial in Cincinnati, Ohio. Today I am speaking on behalf of the National League for Nursing (NLN), which is the official accrediting agency for nursing education and represents approximately 2,000 agencies and 15,000 individuals dedicated to improving the quality of health care through nursing education. As Vice-President of the hospital, my administrative responsibilities include the school of nursing, nursing service, risk management, medical records, and certain clinical areas such as long term care.

Our testimony addresses the Administration's 1987 budget proposal to eliminate the Medicare pass-through for nursing education. The NLN opposes the elimination of this funding because of the impact it would have on nursing education programs and on the collaborative arrangements between hospitals and schools of nursing for the clinical placement of nursing students—arrangements that enhance care that Medicare beneficiaries receive in hospitals with these clinical education programs. We urge the committee to reject the Administrations proposal and to support a more thorough examination of Medicare support for clinical education as the basis for future policy revision. We will explain our position in the sections below.

BACKGROUND

Since its inception, the Medicare program has supported clinical education for nursing, medicine, and the allied health professions. Medicare adopted this policy on the premise that students in these clinical educational programs provided patient care services. Furthermore, Medicare recognized that as a purchaser of hospital services it shared a responsibility for supporting the education of students who would be the next generation of health care professionals.

Clinical placement experiences are an essential component in all nursing curriculum and are part of the NLN accreditation standards. In its accreditation program, NLN accredits 140 masters level nursing education programs, 451 baccalaureate nursing education programs, 453 associate degree, 249 diploma, and 150 licensed practical nursing programs. For each of these types of programs, there are clincial rotations arranged with hospitals for the students; clinical experiences. For these experiences, student nurses (under joint hospital staff and nursing school faculty supervison) provide a variety of patient care services.

Accurate data concerning the full extent of Medicare support for the cost of these clinical placement programs are unavailable. In a number of conversations with officials at the Health Care Financing Administration (HCFA) we have learned that present hospital costs reporting practices make it difficult to quantify the full extent of financial support from Medicare for nursing education. HCFA estimates that for 1982 Medicare expenditures for all allied health and nursing clinical programs totaled about $200 million [illegible]oximately 600 hospitals participating in the Medicare program received these [illegible]s.

However, even HCF[illegible]ficials emphasize the need for caution in relying on the accuracy of these dat[illegible]t, the data are several years old and may not reflect the current amount or [illegible]ation of these funds. Second, these data do not identify the types of arrangemen[illegible] between hospitals and nursing educational programs. This information is essential for an accurate accounting of the flow of Medicare funds for nursing clinical education.

What we do know is that, because of stipulations in the Medicare law, most of the money is allocated for nursing education programs that are operated directly by providers. Each hospital identifies its costs for hosting these programs and claims reimbursement from Medicare for its proportionate share. These costs are incurred for items such as faculty salaries, equipment, classroom space, and other related overhead expenses. This policy has made it possible for hospitals to develop mutually beneficial arrangements with schools of nursing.

The clinical placement of nursing students is seen as a benefit to the schools from an educational and learning perspective. It is a benefit to the hospitals because it facilitates nurse retention and recruitment, helps provide patient care (especially where there are nursing shortages), and provides innovations in nursing care because of the involvement of faculty with leadership skills and expertise.

ADMINISTRATION'S BUDGET PROPOSAL

Mr. Chairman, as you know, the Administration's 1987 budget proposal includes total elimination of Medicare financial support for the clinical education of nursing and allied health professions. These changes would be implemented through regulations, without any congressional mandate. The NLN strongly believes that it is inappropriate and unwise to make changes in the present policy without direction from Congress.

Elimination of the current pass-through for nursing clinical education would threaten the viability of many nursing education programs and interfere with patient care services. Many hospitals would be left with fewer vital nursing resources. These resources help ensure that an adequate standard of care is rendered to Medicare beneficiaries and all other patients.

Furthermore, hospital administrators in many geographic areas are reporting nursing shortages and difficulties in recruiting nurses. To eliminate the pass-through monies would further diminish nursing care delivered to Medicare patients—a group which has already weathered its share of upheaval in the health care system.

Unfortunately, at this point in time, anecdotal reports and sparse data from HCFA are all we have to go in formulating Medicare's policy regarding the clinical cost of nursing education. Therefore, we wholeheartedly support the provision in the 1985 reconciliation bill (HR3128) whereby Congress directed the Department of Health and Human Services (DHHS) to conduct a study on the nursing education activities reimbursable under Medicare. The future of the reconciliation bill is still unclear. However, we urge your Committee to endorse this study and take whatever steps are necessary to promote its implementation as soon as possible. In that way, Congress and the Administration can formulate a rational and timely policy regarding nursing education support under Medicare. We believe that it is premature to eliminate federal funding for nursing education under Medicare until all key players (Congress, the Administration, nurse educators and hospital administrators) have a more precise picture of the flow of these funds.

Furthermore, we believe it is inconsistent to eliminate Medicare funding for nursing education while continuing similar support for clinical education in medicine. We recognize the differences between the allocation of funds for graduate medical education (GME) and nursing clinical education. And we acknowledge that nursing students are not salaried employees, as are medical interns and residents. However, without more accurate costing out of the costs and benefits to the hospitals and schools for the clinical placement of nurses, it would be shortsighted to wipe out these funds altogether.

Mr. Chairman, a sense of urgency compounds the picture because of the Administration's intent to issue proposed regulations this month that would implement its budget proposal. The NLN urges this Committee to call on the Administration to postpone these regulations until completion of the study included in HR3128.

We are committed to working with you and the Administration to develop further information concerning the current level of financial support and the distribution of these funds. Toward that end, the NLN conducted a survey on the clinical placement of nursing students. When we complete our date analysis, we would be pleased to share our findings with you and the Administration.

Mr. Chairman, I thank you for the opportunity to present this statement today and am willing to answer any questions from you or the other Committee members.

Mr. JACOBS. Thank you, Nurse Powell.

Mr. Gradison.

Mr. **Gradison.** Mr. Chairman, I would like to thank the panel for their appearance and it is particularly good to have such an outstanding witness from home. It is good to see you and see Good Samaritan Hospital so well represented.

Ms. **Powell.** Thank you.

Mr. **Jacobs.** Jack, I believe you had some other point you wanted to make.

Mr. **Owen.** I hope that as you look at the Medicaid issue on this budget, we heard about the poor and the needy and in this whole competitive arena we are in now, the poor's uncompensated care is becoming more and more of a problem. We would hope that Medicaid would not be capped and that your committee in looking at this budget would take this into serious consideration.

Mr. **Jacobs.** Our committee is not likely to do much about Medicaid since we do not have any jurisdiction over it.

Mr. **Owen.** A little pressure would help.

Mr. **Jacobs.** We can come up with that.

Mr. O'Brien and Dr. Freedman, we are very, very grateful for your contributions to the record as well. The panel is excused.

The committee will stand in recess until the vote on the floor has been taken and then we will resume the hearing. There will be no break for lunch.

[Brief recess.]

Mr. **Coyne** [presiding]. The hearing will come to order, please.

The next panel we will hear from is a panel on physician reimbursement cuts, and from the American Medical Association, Dr. Alan Nelson; Franklin B. McKechnie; and LaSalle Leffall.

You can proceed in any order that you wish.

STATEMENT OF ALAN R. NELSON, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, AND BRUCE BLEHART, DIVISION OF LEGISLATIVE ACTIVITIES, AMA

Dr. **Nelson.** Mr. Chairman, my name is Alan R. Nelson. I am a physician in the practice of internal medicine in Salt Lake City, UT. I am also vice chairman of the board of trustees of the American Medical Association. Accompanying me is Bruce Blehart of the association's division of legislative activities.

We are concerned that Medicare can ill afford yet another repetition of budget cutting and squeezing while simultaneously ignoring the major issue of the future of this program. Steps must be taken to avert a situation where the coming generation of Americans will have paid into the Medicare Program for their entire working lifetimes only to discover that Medicare is no longer able to meet their needs. It is time to acknowledge the widening generation gap, the inherent problems of the current intergenerational transfer of resources, and the improved financial circumstances of the elderly relative to the working young.

Mr. Chairman, it is essential that future Medicare revisions address the long-term stability of the program. It is time to make the program responsive to the realities of Federal budgets, not by cutting into benefits for all beneficiaries, but by adapting the program to cover the full needs of those elderly in financial need.

The AMA recognizes the significant problems caused by huge Federal budget deficits; however, we seriously question the appropriateness of further cuts in the Medicare Program in light of the fact that this program has been the object of dramatic cuts in the past few years. Moreover, the President is proposing major increases in the defense budget and has not proposed any cuts in certain areas, such as Social Security. We believe that all segments of the Federal budget should be examined for potential budget savings, so that meritorious programs can receive adequate levels of funding.

The AMA has serious concerns over the President's proposals concerning physician reimbursement. Past congressional actions have resulted in physicians being subjected to substantial limitations in both the amount they may be reimbursed by the Medicare Program and the amount that they may charge their Medicare patients. While the physician fee and reimbursement freeze imposed by the deficit reduction acts were severe, they are but a continuation of a series of steps taken since 1969 that have lowered Medicare reimbursement for physician services.

The mandatory freezes, coming on the heels of a voluntary freeze on all fees, with which two-thirds of our members complied, results in an unfair shift of costs to non-Medicare patients, such as young families. Our employees' salaries are not frozen, our supply and rent costs are not frozen, and our malpractice premiums certainly are not frozen.

The proposal calling for the modification to the Medicare Economic Index or MEI would only serve to exacerbate its already adverse effects. The MEI has failed to serve as an accurate measure of inflation over the period of 1976 to today. Of greater relevance is that fact that it has also failed to recognize or measure the level of cost increases that the medical care community has faced as measured by the rate of increase in the medical care component of the CPI.

The AMA believes that if an inflation index is to be used in updating physician reimbursement levels, such an index should accurately measure changes in the cost of providing health care services for Medicare beneficiaries. The MEI does not accomplish this.

The AMA is also greatly concerned that the proposed modification to the MEI would be applied retroactively. Such an application would result in a negligible increase in the prevailing charge level and would, in effect, continue the freeze on physician reimbursement for another year.

The AMA is concerned with the budget proposal calling for selective application of special reimbursement controls. We question the appropriateness of having the Secretary of HHS make a determination that a service is "overpriced," especially in situations where the methodology for setting the reimbursement is set out in the law and is followed.

The AMA is anxious to cooperate in developing mechanisms to assure that fees are fair and equitable. We are working with Harvard University in establishing a resource cost-based relative value study that would provide a coherent and comprehensive system to assure that current inequities in fees are straightened out. We also encourage local committees of physicians to provide adjudication of fee complaints, if we can be certain of protection from FTC harassment.

These efforts, along with free competition among various delivery systems, provide a much more rational approach to assure reasonable fees.

In conclusion, we stand ready to work with both Congress and the administration in analyzing the Medicare Program and in looking for solutions to the future problems facing the Medicare Program.

I'll be pleased to answer any questions, Mr. Chairman.

[The prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Presented by

Alan R. Nelson, M.D.

RE: Medicare Proposals in the Administration's FY 1987 Budget

March 6, 1986

Mr. Chairman and Members of the Subcommittee:

My name is Alan R. Nelson, M.D. I am a physician in the practice of Internal Medicine in Salt Lake City, Utah. I also am Vice Chairman of the Board of Trustees of the American Medical Association. Accompanying me is Bruce Blehart of the Association's Division of Legislative Activities

The AMA is pleased to have this opportunity to present its views on the Medicare proposals set forth in the President's FY87 Budget. We hope that this hearing will serve as a springboard for addressing future directions for the Medicare program. We are all concerned that Medicare can ill afford yet another repetition of budgetary cutting and squeezing while simultaneously ignoring the major issue of the future of this program. While the Administration's budget proposals must be addressed, it is imperative to recognize that it is not too soon to start looking to the needs of the next generation of Americans who are looking to the Medicare program to assure their future access to health care services.

It is no longer shocking to hear predictions that the Medicare program is heading for fiscal bankruptcy in the future. The unanswered question is exactly when the program will run out of funds. Whether that point is to be reached in the year 2000 or 2010 is irrelevant. What is relevant is the fact that bold steps must be taken to avert a situation where the coming generations of Americans will have paid into the Medicare program for their entire working lifetimes only to discover that Medicare is no longer able to meet their needs.

The American Medical Association has recognized this fact, and the Association has embarked on an intensive process to examine this problem and to come forward with ideas designed to assure a sound program that will guarantee the provision of health care services for coming generations when they reach the age of Medicare eligibility. The Association initially addressed these issues when it issued a report in June, 1984. This report specifically looked at the coming financial crisis Medicare is facing, set out guidelines for use in establishing future directions for Medicare, contained interim proposals to address the short-term fiscal needs of the program, and listed directions for the future of Medicare. This was but the first step in addressing this essential issue.

Our analyses have indicated that it is time to acknowledge the widening generation gap, the inherent problems of the current intergenerational transfer of resources, and the improved financial circumstances of the elderly relative to the working young. Increased individual responsibility related to one's ability to pay can protect the program's integrity by continuing to assure coverage for appropriate care for those with less financial resources.

Mr. Chairman, it is essential that future Medicare revisions address the long-term stability of the program. It is time to make the program responsive to the realities of the federal budgets -- not by cutting into benefits -- but by adapting the program to cover the full needs of the elderly in financial need and by introducing greater responsibility for those who have adequate means to contribute more for their own care.

The AMA is well on the way to completing this study on the Medicare program, with recommendations for the future. We look forward to sharing the study and recommendations as soon as it is available.

THE PRESIDENT'S 1987 BUDGET

The Administration's budget calls for a FY87 deficit of $143.6 billion based on total federal spending, or outlays, of $994 billion, and revenues of $850.4 billion. (The deficit figure is $.4 billion below the $144 billion deficit ceiling set by Gramm-Rudman-Hollings.) The proposed 1987 budget calls for increases of $24 billion in budget authority and $12.7 billion in outlays in the budget of the Department of Health and Human Services (HHS). This would bring the FY87 budget authority for the Department to $373.1 billion and outlays to $345.6 billion. The Administration's overview for the FY87 budget indicates that its request represents a restraint in the growth of spending for HHS, and that this budget "achieves outlay savings of $7.8 billion, or 2.2% below 1987 current services estimates."

The AMA recognizes the significant problems caused by huge federal budget deficits. However, we seriously question the appropriateness of further cuts in the Medicare program in light of the fact that this program has been the object of dramatic cuts in the past few years. The President has targeted Medicare for a disproportionately large share of cuts and is proposing additional Medicare program modifications even while previous changes, such as DRGs and the freeze on physician reimbursement and fees, have either not been fully implemented or been allowed to run their course. Moreover, the President is proposing major increases in the defense budget and has not proposed any cuts in certain areas such as Social Security. We believe that all segments of the federal budget should be examined for potential budget savings so that meritorious programs can receive adequate levels of funding.

Mr. Chairman, the AMA recognizes that many of the proposals you are considering stem from the perception that physicians are unwilling to sacrifice and hold the line on health care costs. This is not the case. The AMA is strongly committed to restraining health care expenditures. In response to an AMA call to all physicians in February 1984, physicians voluntarily agreed to freeze their charges to all patients, not just Medicare beneficiaries, for a one-year period. Compliance with this freeze was substantial, with 63% of all physicians not raising their fees for the entire year that the fee freeze request was in effect. The resulting savings from this voluntary activity was an estimated $3.1 billion dollars that otherwise would have been spent for physicians' services. The voluntary freeze was a significant factor in the recent slow-down in the rate of increase in the cost of physicians' services.

Even though the one-year voluntary fee freeze period has expired, the AMA continues to urge physicians to consider each patient's financial needs when setting charges and to accept Medicare assignment, reduce fees, or charge no fee at all in financial hardship cases.

It also must be noted that a continuation of the federal policy of freezing reimbursement and fee levels is most injurious to those who agreed with the position of the AMA and who voluntarily froze their fees. These physicians have been penalized for their good faith effort to hold the line on costs. Failure to recognize this fact by yet a further extension of the freeze would be wholly inequitable.

BUDGET PROPOSALS TO MODIFY THE MEDICARE PROGRAM

The Administration's FY87 budget contains numerous line-item proposals calling for modifications to the Medicare program through either legislative or regulatory action. We hope to expand on the comments made today when and if these proposals are published.

Physician Reimbursement Reform (savings of $432 million in 1987) - Regulatory modifications are to be proposed to "slow the rate of growth" in the amounts paid for physician reimbursement. These modifications will include proposals to:

- modify the Medicare economic index to "correct for the historical overstatement of housing costs;"
- control payments for specific procedures that are "overpriced because of technological or productivity advances, or geographic variations;"
- reduce "excessive payments" for lens replacements and adopt stricter criteria to ensure the medical necessity of lens replacements; and
- limit payments for physicians who provide stand-by anesthesia services, and for "unnecessary assistants at surgery."

The AMA has serious concerns over the President's proposals concerning physician reimbursement. Past Congressional actions have resulted in physicians being subjected to substantial limitations in both the amount they may be reimbursed by the Medicare program and the amount that they may charge their Medicare patients. While the physician fee and reimbursement freeze imposed by the Deficit Reduction Act in 1984 were severe, they are in fact but a continuation of a series of steps taken since 1969 that have lowered Medicare reimbursement for physician services. The result of these actions has been that physician reimbursement under Medicare consistently has been compressed to a point where the maximum Medicare reimbursement rate, the "prevailing charge," usually does not reflect the actual prevailing charge for a service in a community. This is borne out by the fact that as of the end of calendar year 1984 over 81% of billed charges on claims were not recognized by Medicare because the so-called "prevailing rate" precluded their recognition. To put this fact in perspective, only 18.3% of all claims were ~~paid~~ submitted at levels either at or below Medicare prevailing charge screens. (Attached to this statement is an Appendix setting forth an historical perspective on limits imposed on physician reimbursement under Medicare.)

Medicare Economic Index The proposal calling for the modification to the Medicare Economic Index (MEI) would only serve to exacerbate the already adverse effects of the existing MEI. As illustrated by the graph attached to this statement, the MEI has failed to serve as an accurate measure of inflation over the period of 1978 to today. Of greater relevance is that fact that it has also failed to recognize or measure the level of cost increase that the medical care community has faced, as measured by the rate of increase in the medical care component of the consumer price index (CPI).

The AMA believes that if an inflation index is to be used in updating physician reimbursement levels, such an index should accurately measure changes in the cost of providing health care services for Medicare beneficiaries. The MEI does not accomplish this. While a further modification to the MEI to recalculate housing costs (by taking into consideration rental costs) would be consistent with recent modifications to the CPI, the indicator still would fail to provide an accurate measure of the industry to which it is applied and would further exacerbate the problems of the MEI's failure to reflect accurately inflation in general and medical costs specifically.

The AMA is also greatly concerned that the proposed modification to the MEI would be applied retroactively. Such an application would result in a negligible increase in the prevailing charge level and would, in effect, continue the freeze on physician reimbursement for an additional year. This would be highly inequitable, especially in light of the fact that Medicare reimbursement for physician services has not been increased since July 1, 1983. Moreover, the payment level set on that date was based on charges made in 1982. At this time, physicians have gone for almost one-half decade without adequate recognition of the value of the services they provide. The AMA strongly objects to the reformulation of an already inadequate index in such a way as to make it even more inequitable.

Controlling Payments for Specific Procedures. The AMA is concerned with the budget proposal calling for selective application of special reimbursement controls. We question the appropriateness of having the Secretary of HHS make a determination that a service is "overpriced," especially in situations where the methodology for setting the reimbursement level is set out in the law and is followed. By way of example, the budget item calls for controls to be placed on services deemed "overpriced" due to geographic variations. We seriously question, however, the ability and the appropriateness of the Secretary coming up with a methodology to establish reimbursement limits based on geographic variations. John Wennberg, M.D., the recognized scholar studying the issue of medical care variations, points out (in his recent editorial published in the New England Journal [January 30, 1986]) that allowing reimbursement levels to be cut based on statistical norms could result in following the theory that the "least is always best" to fulfill the apparent governmental edict to save money.

The AMA recognizes that the issues raised by geographic variations must be addressed. However, we agree with Dr. Wennberg that these issues must be approached from the viewpoint of assuring the availability of the best quality care, and not from the strict view of cost cutting. To this end, state Medical societies have worked with Dr. Wennberg in the past, and the AMA currently is working with Dr. Wennberg in examining area variations.

The AMA is very concerned over the possibility of arbitrary actions taken in the name of cost-saving that may actually interfere with the ability of physicians to provide quality medical care services. Just as we will be examining these issues when they are issued in the form of proposed regulations, we hope that this Committee also will be closely monitoring this process.

Anesthesia Services - Payment Limitation. This item in the budget apparently deals with the possible creation of a differential in payment levels for anesthesia services depending upon whether the beneficiary receives local or general anesthesia. We do not believe that it would be appropriate for a hard and fast rule to be implemented that would set specific differentials based on the type of anesthesia the patient receives.

It is a gross over-generalization to assume that where an anesthesiologist is actively involved in the patient's care that he or she provides a lesser service when a local anesthetic is used during a surgical procedure. This is especially true with the Medicare population, as Medicare beneficiaries bring additional risk factors to bear in a surgical situation because of their health status. Also, local anesthesia can, in fact, carry further risk in that the patient is less susceptible to having his or her vital functions controlled by the anesthesiologist. When a patient undergoes general anesthesia, the anesthesiologist actually controls his or her vital functions and literally "breathes" for the patient. The anesthesiologist does not have this level of control when a local anesthetic is used. Therefore, it is much more difficult to assist the patient if problems occur while a local anesthetic is being used. We strongly recommend that this issue be scrutinized closely if regulations are forthcoming to limit payments for these so-called "stand-by anesthesia services."

Direct Medical Education (savings of $495 million in 1987) - Regulatory changes would be proposed to eliminate medicare reimbursement for the education expenses of residents and to eliminate Medicare reimbursement for the training of allied health personnel. Payments for the services of residents and interns would be continued but with hospital-specific limits on residents' salaries.

Legitimate medical education expenses incurred for classrooms, libraries and other education costs should not be ignored in determining the fair share of such expenses to be borne by the Medicare program. We are particularly concerned that the proposal would inappropriately separate the "service" and the "education" components of residency training.

Indirect Medical Education (savings of $1.110 billion in 1987) - By legislation, the indirect medical education payment would be halved. By regulation, the formula would be revised to reflect that Medicare per resident costs increase at a slower rate when teaching programs get larger.

Reducing the indirect medical education adjustment by one-half would not be in the best interest of patients receiving care at teaching hospitals. We support a reduction in the indirect medical education adjustment from the current level of 11.59% to no less than 8.7% on a curvilinear basis.

Home Health Copayment (savings of $100 million in 1987) - A copayment equal to 1% of the inpatient hospital deductible would be proposed for home health services. The copayment, $4.92, would not apply to those visits following a hospital or skilled nursing facility stay. In addition, the copayment would not apply for visits after the first 100 visits. Regulatory requirements would be issued calling for "enhanced medical review of the appropriateness" of home health services.

The AMA supports appropriate copayment levels as a means of incorporating individual responsibility in care decisions. We support the President's proposal to extend copayment requirements to home health care services.

Clinical Laboratory Fees - Payment levels for clinical laboratory services, regardless of setting, would be maintained at existing levels for one year. When the current fee schedule for tests performed in hospital outpatient departments expires in July 1987, cost limits will be established by regulation to "preclude excessive spending for hospital laboratory services."

We oppose a freeze on fees for clinical laboratory services or other physician services. The budget assumes that the current spending level for hospital laboratory services is "excessive." Such a term is subject to serious misinterpretation and could be applied to reach arbitrary total cost limits without regard to equity or quality patient care. Cost limits and fee freezes in the field of laboratory services are particularly onerous, since the current fee schedule for these services is already set at 60% of the 1983 prevailing charge for non-hospital clinical laboratory services and at 62% for clinical laboratory services provided in the hospital laboratory. We oppose extending these improper limitations.

Part B Premium (additional income of $725 million in 1987) - Separate premiums would be established for individuals and third-party payors. The premium for individuals would be gradually increased over the next five years, at a rate of two percentage points per year, until the rate equals 35% of estimated program costs. Third-party payors who buy Part B coverage would have premiums set at 50% of program costs.

The AMA supports increasing the Part B premium to fund at least 35% of the program costs. The Part B premium was originally intended to cover 50% of Medicare program costs. However, we are concerned about an immediate increase in the premium to 50% for third-party payors, and we recommend that such a modification be phased-in. Such an increase, particularly without some phase-in period, could prove onerous to states that "buy in" to the Medicare program for all jointly eligible Medicare and Medicaid beneficiaries.

Initial Point of Medicare Eligibility (savings of $265 million in 1987) - Medicare eligibility will begin on the first day of the first month following the month in which the individual turns age 65.

The AMA supports this proposal.

Part B Deductible (savings of $310 million in 1987) - The Part B deductible would be increased to $100 in 1987 and thereafter be indexed to the Medicare economic index.

The AMA supports this proposal.

Working Aged Extension - Legislation would be proposed to make Medicare the secondary payor for all beneficiaries over age 69. The secondary payor provisions would be extended to disabled beneficiaries who are also covered under a working spouse's employer health insurance plan.

The AMA supports this proposal.

Hospital Capital Costs (savings of $456 million in FY87) - A regulatory proposal would be implemented to incorporate Medicare's payment for capital costs into the PPS system.

The AMA is concerned that the proposed modification in capital cost reimbursement could have a severe impact on the ability of patients to receive needed medical services. A direct add-on to all DRGs could provide windfalls to certain institutions while failing to adequately compensate others. The Association believes that any change in the methodology used for recognizing capital costs must allow an adequate transition period so that hospitals may continue to meet existing capital obligations.

PRO Funding - The budget proposes a $9 million increase in PRO funding for FY87 to a level of $169 million.

The AMA continues to support adequate funding for the PRO program. However, the Association continues to be concerned that PROs are emphasizing cost containment at the expense of quality assurance. We believe that quality assurance should be the first order of business for

PROs and that where modifications in PRO requirements are made that they not overlook quality.

GRAMM-RUDMAN-HOLLINGS

Mr. Chairman, in addition to presenting these concerns with the Medicare proposals in the FY87 budget, we believe it is appropriate to provide this Committee with our concerns over the Gramm-Rudman-Hollings legislation. The AMA supports the goal of Gramm-Rudman-Hollings to eliminate deficit spending and achieve a balanced budget. Fiscal responsibility by government is imperative. However, the budget balancing mechanisms created by law are unfair. Where the President and the Congress fail to agree on meeting deficit targets, the law provides for applying indiscriminately automatic cuts without any regard for the merit of the affected program. Where cuts are to be made, they should be the result of rational action, as opposed to the process now mandated by the Gramm-Rudman-Hollings imperative. Therefore, we have developed the following guidelines for addressing implementation of the Gramm-Rudman-Hollings program:

1) The health and medical portion of the federal budget has been targeted for a disproportionate share of cuts over the last five years. The AMA and others (representing hospitals, nurses, senior citizens, members of Congress and government studies) have all indicated concern over the impact of past budget reductions and especially over new reductions. It is clear that arbitrary automatic reductions that come from less than 50% of the federal spending programs through sequestration is the wrong approach.

2) The entire federal budget for FY '87 should be closely examined to ensure that the Gramm-Rudman-Hollings automatic cuts are not necessary. All federal departments, agencies and programs should contribute savings to help achieve the deficit reductions necessary to meet the Gramm-Rudman-Hollings targets and avoid arbitrary actions.

3) The AMA supports consideration of a combination of budget cuts and limited revenue increases as part of a comprehensive program to meet the Gramm-Rudman-Hollings targets.

4) It is not right that only about one-half of federal expenditures are subject to the automatic Gramm-Rudman-Hollings cuts. The Gramm-Rudman-Hollings Act should be amended so that no federal activity is exempt from consideration for automatic Gramm-Rudman-Hollings reductions.

5) Gramm-Rudman-Hollings provisions should be amended to give federal departments greater flexibility in allocating cuts within their units.

Mr. Chairman, we will be pleased to address any questions that the Committee may have.

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Historical Perspective - Physician Reimbursement under Medicare

Since the inception of Medicare, Congress and the Department of Health and Human Services (formerly the Department of Health, Education and Welfare) have taken actions that have resulted in reductions in Medicare reimbursement for services provided by physicians for Medicare beneficiaries. The result of these actions has been that physician reimbursement under Medicare consistently has been compressed to a point where the maximum Medicare reimbursement rate, the "prevailing charge," usually does not reflect the actual prevailing charge for a service in a community. This is borne out by the fact that as of the end of calendar year 1984 only 18.3% of all claims were submitted at levels either at or below Medicare prevailing charge screens. The following information details past actions that have served to limit physician reimbursement under Medicare:

> In 1969, the prevailing charge was lowered from the 90th percentile to the 83rd percentile of customary charges.
>
> In 1970, the prevailing charge was lowered to the 75th percentile of customary charges.
>
> For the second half of the 1971 fiscal year, physician's customary charges were based on the physician's median charge during the 1969 calendar year.
>
> In August 1971, nationwide wage and price controls were imposed. While these controls were lifted seventeen months later for most of the economy, they still were retained for physicians for an additional fifteen months -- until May 1974.
>
> In 1972, Congress established further restraints through use of an economic index as a means to limit the rate of annual increase in prevailing charges. In 1976, the economic index was used to set the prevailing charge limits using fiscal year 1973 charge screens that were based on physicians' charges during calendar year 1971.
>
> In 1984, the Deficit Reduction Act modified physician reimbursement in the following ways:
>
>> The act created two classes of physicians, "participating" physicians who agreed to accept all Medicare claims on an assigned basis and "non-participating" physicians who may continue to accept assignment on a claim-by-claim basis;
>>
>> Medicare maximum reimbursement levels for physician services, customary and prevailing charge levels, were frozen for the period of June 30, 1984 to September 30, 1985 (If no freeze had been imposed by the Deficit Reduction Act, the economic index would have allowed a 3.34% increase of the prevailing charge level on July 1, 1984.);

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Department of Federal Legislation, Division of Legislative Activities

The act eliminated the increase in fee profiles that should have occurred on July 1, 1984 and delayed from July 1 to October 1 any future annual increase or update in fee profiles, with the next increase scheduled for October 1, 1985; and

Fee increases for services provided Medicare beneficiaries by "non-participating physicians" above the level charged for the period of April, May and June of 1984 were prohibited during this 15-month period. (Participating physicians were allowed to increase their fees for Medicare beneficiaries, but they are not allowed to collect this increased fee because of the agreement to accept assignment on all Medicare claims.)

The Emergency Extension Act, passed on September 30, 1985, froze physician payment levels at the rates in effect on September 30, 1985 for 45-days. (This Act prevented a 3.15% economic index increase from being applied to Medicare prevailing charge levels on October 1, 1985.) This Act also rolled back the actual charge levels allowed physicians who "participated" in FY85 but who had not agreed to "participate" in FY86 to their charge levels in effect during the period of April, May and June, 1984. This Act effectively prohibited the scheduled October 1, 1985 increase in fee profiles from taking place. At the close of the first session of the 99th Congress, the extension act was again extended, and physician fees and reimbursement levels continue to be frozen through March 15, 1986.

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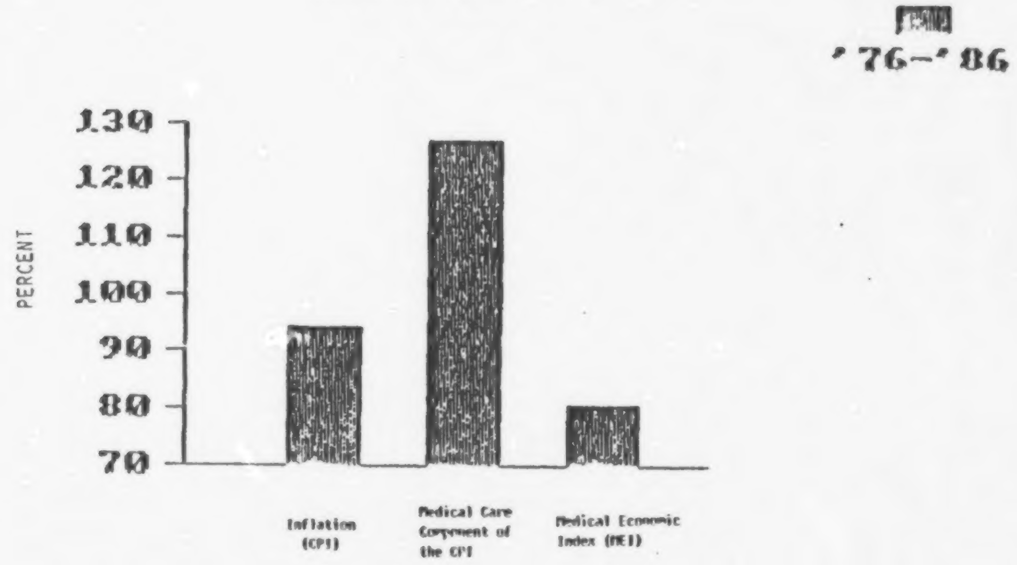
CUMULATIVE PERCENTAGE INCREASE



Prepared by: Center for Health Policy Research
American Medical Association

STATEMENT OF FRANKLIN B. McKECHNIE, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, AND JESS B. WEISS, M.D., CHAIRMAN, COMMITTEE ON ECONOMICS

Dr. McKechnie. Yes, Mr. Chairman. Thank you for your time. I am the president of the American Society of Anesthesiologists, which is an association of some 22,000 physicians specializing in anesthesia, and we are vitally interested in the issue of so-called stand-by anesthesia.

To speak for us, I have asked the chairman of our Committee on Economics, Dr. Jess Weiss.

Dr. Weiss. Mr. Chairman, I am a practicing anesthesiologist from Boston. I am vice chairman of the department at the Brigham Women's Hospital, and I speak as chairman of the Committee on Economics for the American Society of Anesthesiologists. I will attempt to address briefly some of the misconceptions that exist these days with regard to the use of the term "standby anesthesia."

We believe that there is a great deal of misunderstanding which has produced what we think are erroneous conclusions. This has led to drastic reductions in reimbursement to anesthesiologists for these services. We are concerned that this road, if continued to be tread upon, will result in restricted access for Medicare patients to the kind of quality care that they require because of their age and because of the complicating illnesses that they may have.

The term "stand-by anesthesia" is an unfortunate one, and it has stemmed from the days when hospitals, surgeons, and obstetricians requested anesthesiologists to be present in the hospital, so that if there was a need for anesthesia care in a particular patient, that care would be available immediately This kind of hanging around the hospital, as the term was loosely used, is not what we are addressing when we talk about stand-by anesthesia. We would prefer that the term be "standby" restricted to cover just that situation of standing-by, and that our specific anesthesia services to a patient be termed "monitored anesthesia services." We regard these services as similar to and if not equal to, then certainly even greater in intensity than, those services that we render to patients when we administer the kind of anesthesia care that is classically thought of as anesthesiology.

Indeed, it is not uncommon that monitored anesthesia care of these patients, in which we are present in the operating room, monitoring the patient's physiological systems such as respiration and cardio-circulatory function and administering such drugs as may be necessary to maintain these functions, indeed, may be more difficult for the patient and more challenging to the anesthesiologist than the classical forms of anesthesia.

Unfortunately, as you heard earlier from Dr. Desmarais, there are already seven Medicare carriers in this country that have so drastically modified their reimbursement for these services that we are concerned that this change will alter our ability to provide these services. In our view, this would result in a lessening of the degree of care that these patients require.

The misconceptions associated with so-called stand-by anesthesia, as I have tried to point out, derives from the misconception that somehow this is a lesser service to the patient than if we were administering the more classic forms of anesthesia.

I would tell you that we have been in conversation as recently as yesterday with HCFA officials with regard to this issue, and we are attempting to continue these conversations to arrive at a situation whereby both sides of the equation may be satisfied. We, of course, would like to be able to be adequately reimbursed. We recognize the budgetary considerations that cause the actions that are being contemplated, but believe that the administration is acting under misconceptions about anesthesia services to the patient. These misconceptions can lead to no other result than that of a lessening of the quality of care these patients require.

Thank you.

[The prepared statement follows:]

# STATEMENT OF FRANKLIN B. MCKECHNIE, M.D. AND JESS B. WEISS, M.D.
for the
AMERICAN SOCIETY OF ANESTHESIOLOGISTS
BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS & MEANS
U.S. HOUSE OF REPRESENTATIVES
March 6, 1986

Our names are Franklin B. McKechnie, M.D. and Jess B. Weiss, M.D. We are respectively practicing anesthesiologists in Winter Park, Florida and Boston, Massachusetts, and are respectively the current president and the current chairman of the Committee on Economics of the American Society of Anesthesiologists (ASA). We appreciate this opportunity to testify before the Subcommittee on behalf of ASA.

The Administration's fiscal year 1987 budget proposals contain, among other things, a proposal to issue regulations limiting payments to physicians who provide standby anesthesia services. We understand that the Administration expects that implementation of this proposal would result in savings of some $70 million annually. Our purpose in appearing here today is to comment on that proposal.

While recognizing the budgetary constraints being faced by the Administration and Congress this year, we believe such budget savings should be done in a manner which will minimize potentially adverse impacts on patient care.

In our view, the Administration's proposal to limit payment for standby anesthesia is based on the mistaken conclusion that "reduced services" to Medicare patients are somehow involved. This we believe is principally due to the confusion surrounding the term "standby anesthesia," even though such services frequently require more difficult medical care by the anesthesiologist than that provided to the patient under general anesthesia.

Careful consideration of this issue must be given to avoid any reduction in adequate care for Medicare patients at risk, not only because of advanced age but because of complicating conditions.

We think it is important, first, to make sure that the Subcommittee understands what one means by "standby anesthesia." In general, the term has been used to cover two very different forms of service by an anesthesiologist:

1. The term has been used to refer to services of an anesthesiologist, present somewhere in the hospital and available to provide requisite anesthesia care to any patient in need of cardio-respiratory monitoring and/or resuscitation, surgical or obstetric anesthesia, respiratory care, or pain relief. This form of limited availability has now been properly defined as a physician service to the hospital or to the patient population as a

whole, rather than a physician service to a specific patient. It is usually reimbursed by third party payers such as Blue Cross or Medicare Part A as part of hospital cost reimbursement.

2. The term has also been used to refer to instances in which an anesthesiologist has been called upon by a surgeon or an obstetrician to provide specific anesthesia services to a particular patient undergoing a planned surgical or obstetrical procedure, in connection with which the surgeon or obstetrician administers local anesthesia or, in some cases, no anesthesia at all. In such a case, the anesthesiologist is providing specific services to the patient and is in control of his or her non-surgical or non-obstetrical medical care, including the responsibility of monitoring of his or her vital signs, and is available to administer anesthetics or provide other medical care as appropriate.

The preamble to the Medicare TEFRA regulations specifically acknowledges that "standby anesthesia" is, under these latter circumstances, a physician service to the individual patient and thus reimbursable under Medicare Part B. HCFA has advised its carriers to reimburse physicians for this service "the same as for any other anesthesia procedure," provided that the physician is physically present in the operating suite monitoring the patient's condition, making medical judgments regarding the patient's anesthesia needs, and ready to furnish anesthesia services as necessary.

Unfortunately, use of the term "standby anesthesia" has led some third party payers mistakenly to conclude that reduced services by the anesthesiologist are somehow involved. This misunderstanding has resulted in proposals for third-party reimbursement at a level below that of the more classical anesthesia services, namely, the provision of general or regional anesthesia to provide pain relief during a surgical or obstetric procedure. Such reduction has recently been made or proposed by a number of Medicare carriers, and it now appears that the Administration proposes to establish a reduction nationwide through regulatory action. To establish such a pattern of reduced reimbursement creates, we believe, a potential for reduced availability of services to Medicare patients, as well as less than adequate care for many such patients at risk, not only because of advanced age but because of complicating medical problems.

ASA believes the participation of an anesthesiologist in the case of an individual patient under circumstances such as those described by HCFA is often critical to the provision of sound medical care and should be subject to reimbursement at the same level as if a general or regional anesthetic had in fact been administered. ASA also recognizes, however, that this is an area which may involve the provision of anesthesia care where it may not be necessary, given the circumstances of an individual case. ASA believes that proper resolution of this problem requires, not necessarily "across the board" reduction in physician reimbursement, but rather a more precise definition of the circumstances under which such care is medically necessary and therefore fully reimbursable.

ASA first recommends that in order to avoid confusion, a new term should be used to describe those instances in which the anesthesiologist, consistent with HCFA's present reimbursement regulations, is physically present and is providing direct anesthesia care to the patient under the circumstances described a moment ago. We believe that the most appropriate term would be "Monitored Anesthesia Care," which would properly include the following requirements:

1. The service shall be requested by the attending physician and be made known to the patient, in accordance with accepted procedures of the institution.
2. The service shall include:
    a. Performance of a preanesthetic examination and evaluation.
    b. Prescription of the anesthesia care required.
    c. Personal participation in, or medical direction of, the entire plan of care.
    d. Continuous physical presence of the anesthesiologist or, in the case of medical direction, of the resident or nurse anesthetist being medically directed.
    e. Proximate presence or (in the case of medical direction) availability of the anesthesiologist for diagnosis or treatment of emergencies.
3. All institutional regulations pertaining to anesthesia services shall be observed, and all the usual services performed by the anesthesiologist shall be furnished, including but not limited to:

a. Usual noninvasive cardiocirculatory and respiratory monitoring.

b. Oxygen administration, when indicated.

c. Intravenous administration of sedatives, tranquilizers, antiemetics, narcotics, other analgesics, beta-blockers, vasopressors, bronchodilators, antihypertensives, or other pharmacologic therapy as may be required in the judgment of the anesthesiologist.

If these requirements are not met, then depending upon the extent of the deficiency, the anesthesiologist should not be entitled to reimbursement or should be reimbursed commensurate with the care provided.

Assuming that these services are provided, then the issue becomes whether, nonetheless, full reimbursement -- as if a general anesthetic had been administered -- should be made in all cases. It is clear under these circumstances that the medical judgment and skill required of the anesthesiologist, and his expenditure of time, are no different than in cases involving general anesthesia. The question, however, is whether in some or all cases the anesthesia risks inherent in the procedures are also the same as in cases involving general anesthesia.

A case can be made that lesser reimbursement should be permitted when the patient is in normal good health -- except with reference to the condition for which the operation is being performed -- as distinct from instances when the patient is also suffering from a mild or serious secondary disease. The difficulty with this approach is that even in healthy patients undergoing local anesthesia, as in the case today of almost all cataract surgery, there exists a verifiable risk of the patient unpredicably reacting adversely to the local anesthetic so seriously that if the reaction is not immediately treated, death or serious permanent damage can result. If this is so, how can HCFA justify a lesser reimbursement level for care of healthy patients as distinct from those with more serious systemic disease.

Another obvious method of approach is simply to reduce the level of reimbursement across the board. We have great difficulty with that concept, essentially because as pointed out above, we do not believe that the service being provided is any less than that involved in provision of a general anesthetic. The situation is compounded, moreover, by the fact that while all Medicare carriers reimburse anesthesiologists on the basis of a relative value guide methodology, there are probably 30 to 40 different guides, or variations, in use by carriers today, and any proposed reduction in procedural unit values for Monitored Anesthesia Care would almost by definition unevenly impact on anesthesiologists around the country.

We are currently engaged in discussions with HCFA concerning this issue. Our objective is to find a means by which reimbursement remains appropriate to the level of care rendered to each patient, taking into account the judgment and medical skill involved, the risks presented by the procedure and the patient's condition, and the time expended by the anesthesiologist in performing the procedure. It would be unfortunate if this issue were dealt with simply in budgetary terms. Indeed, we suggest that such a course would be ill-advised, and that careful study of this mater is required if we are to avoid doing a serious disservice to Medicare patients.

In the last analysis, decisions of this sort should be made on the basis of medical necessity in the care of the patient -- an issue with which we know that the Congress has demonstrated a continuing concern. At a meeting yesterday with HCFA, we were given a thorough opportunity to describe the medical complexities involved in Monitored Anesthesia Care, and we explored with HCFA representatives reasonable approaches to reimbursement for this type of care that take account of the medical needs of the patients. We are hopeful that these discussions, as they continue, will prove productive. We would be pleased to keep the Subcommittee advised of the progress of our discussions with HCFA.

In short, we want the Subcommittee to know that we are working actively with HCFA on this matter -- in what we believe to be a responsible manner. At least on the basis of our discussions to date, we believe that an appropriate solution can be found before the commencement of the next fiscal year.

Thank you very much.

Mr. COYNE. Thank you, Dr. McKechnie. Dr. Leffall.

STATEMENT OF LaSALLE D. LEFFALL, JR., M.D., F.A.C.S., CHAIRMAN, DEPARTMENT OF SURGERY, HOWARD UNIVERSITY HOSPITAL, ON BEHALF OF AMERICAN COLLEGE OF SURGEONS

Dr. LEFFALL. Mr. Chairman and members of the subcommittee, I am LaSalle Leffall, a general surgeon from Washington, DC. I am a fellow and officer of the American College of Surgeons on whose behalf I appear before you today.

The college is appreciative of this opportunity to share the views of its members about the Medicare provisions of the administration's proposed fiscal year 1987 budget. The American College of Surgeons, Mr. Chairman, is a 73-year-old voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high-quality care for the surgical patient.

The purpose of our testimony is twofold. First, we would like to offer to this committee and place at your disposal our experience and resources for your consideration in the development of alternative approaches for physician reimbursement under the Medicare program.

Second, we would like to identify four principles that we believe are basic to an acceptable payment reform plan.

We have views about what incentives will make for good patient care at affordable cost. We have equally strong concerns that other interests of the patient may be adversely affected by inflexible or rigidly applied payment changes.

In a word, Mr. Chairman, the members of the American College of Surgeons want very much to play a constructive role in your review of changes in payment policies under the Medicare program.

Our study of Medicare payment issues suggests that the first highly critical step is to assure that a plan is fair to each of the parties concerned, patients, physicians, and the Government, by defining the services for which payments will be made.

For many years, the College has played a key role in emphasizing that surgical procedures include preoperative, operative, and postoperative care. Segmenting the operative experience so that it involves multiple payees is not only contrary to the college's concept of surgical responsibility, but can easily add significant and unnecessary expense. Although this global fee concept has been understood for many years, it may admit of further precise definition. We would welcome an opportunity to assist the Government in devising improved definitions of surgical and other payment units for Medicare services.

The second purpose of our testimony is to set forth four principles we believe to be important in the design of any broadly acceptable payment reform plan. These principles are designed first to avoid changes in payment methodology that would have undesirable consequences for beneficiaries from the standpoint of (1) loss of access to care, (2) compromises in quality of care, or (3) burdensome increases in beneficiary costs.

Second, to support the best practice of medical care as now provided and encourage continued improvements in clinical diagnosis and treatment.

Third, to make future costs of services more predictable and acceptable.

And finally, to provide for a system of administration that will assure effectiveness and fairness.

Unless caution is taken, there is the very real risk that two systems of care will be established, one for the privately insured and more affluent segments of the population and a second less desirable one for Medicare and other publicly-sponsored patients. We would hope that such unfortunate results can be prevented.

We believe that the prospects for achieving the objective of beneficiary protection can be much improved by recognizing reasonable variations in the level of fees paid geographically, as well as according to the skill level required by a given service or the skill level of the physician providing the care. But we recognize that excessive medical and surgical fees are a problem in some instances, and that this is an issue that needs to be addressed.

In conclusion, Mr. Chairman, the American College of Surgeons wishes to reemphasize its intention to offer assistance to the Congress in developing any revisions in Medicare physician payment policies and to the administration of implementing any proposals that are adopted.

To that end, the College is hosting a meeting of representatives of the major surgical specialties on March 7 and 8 in Chicago. The purpose of the meeting is to review some of the options for physician reimbursement reform that are being considered in the Congress and to discuss how these options would affect patients and the quality of their care, as well as the practice of surgery.

The four major issues we will be addressing are assistance at surgery, fee variations, defining units of reimbursable services, and physician participation issues. The comments we receive during the course of the meeting will be considered in the College's policy development efforts.

The American College of Surgeons understands that economic and budgetary concerns have been major factors in many recent policy actions under Medicare. We hope that together we can participate in finding methods to address these issues in ways that do not disadvantage patients or cause unneeded and disruptive strain on the medical system itself.

Thank you very much, Mr. Chairman.

Mr. Coyne. Thank you, Dr. Leffall.

[The prepared statement follows:]

Statement of the American College of Surgeons

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Presented by

LaSalle D. Leffall, Jr., M.D., F.A.C.S.

RE: Medicare provisions of the Administration's proposed fiscal year 1987 budget

March 6, 1986

American College of Surgeons
55 East Erie Street
Chicago, Illinois 60611
(312) 664-4050

Summary Statement

American College of Surgeons

The purpose of our testimony is twofold:

1. We would like to offer to this Committee, and place at your disposal, our experience and resources for your consideration in the development of alternative approaches for physician reimbursement under the Medicare program. The College is hosting a meeting of representatives of the major surgical specialties on March 7 and 8. The four major issues related to physician reimbursement reform under Medicare that will be discussed are:
   - assistants at surgery.
   - fee variations.
   - defining units of reimbursable services.
   - physician participation issues.

2. We would like to identify four principles that we believe are basic to an acceptable payment reform plan. These principles are as follows:
   - to avoid changes in payment methodology that would have undesirable consequences for beneficiaries from the standpoint of 1) loss of access to care, 2) compromises in quality of care, or 3) burdensome increases in beneficiary costs:
   - to support the best practice of medical care as now provided and encourage continued improvements in clinical diagnosis and treatment;
   - to make future costs or services more predictable and acceptable; and,
   - to provide for a system of administration that will assure effectiveness and fairness.

STATEMENT

of the

AMERICAN COLLEGE OF SURGEONS

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Presented by

LaSalle D. Leffall, Jr., M.D., F.A.C.S.

RE: Medicare provisions of the Administration's proposed
fiscal year 1987 budget

March 6, 1986

Mr. Chairman and Members of the Subcommittee:

I am LaSalle Leffall, a general surgeon from Washington, D.C. I am a Fellow and an officer of the American College of Surgeons, on whose behalf I appear before you this morning. The College is appreciative of this opportunity to share the views of its members about the Medicare provisions of the Administration's proposed fiscal year 1987 budget.

The American College of Surgeons, Mr. Chairman, is a 73-year-old voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high quality care for the surgical patient. The College provides extensive educational programs for its Fellows and for other surgeons in the United States and elsewhere in the world. It also cooperates in the education of nurses and allied health care practitioners. In addition, it establishes standards of practice, disseminates medical knowledge and provides information to the general public.

In 1918, the College established the nation's first voluntary hospital standardization program, designed to improve the level of patient care in hospitals. It supported this program with its own funds for 35 years. Out of this effort came the Joint Commission on Accreditation of Hospitals (JCAH), the nation's principal hospital survey and accreditation body of which the College is a member. To achieve the goal of excellence in the provision of quality surgical services for patients, the College also maintains strong bonds with physicians in the various surgical specialties through representation on its Board of Governors, as well as through some 11 surgical specialty advisory councils. There are 85 Chapters of the College in the United States and other countries throughout the world.

The purpose of our testimony is twofold. First, we would like to offer to this Committee, and place at your disposal, our experience and resources for your consideration in the development of alternative approaches for physician reimbursement under the Medicare program. Second, we would like to identify four principles that we believe are basic to an acceptable payment reform plan.

With regard to the first purpose of our testimony, we are living in a period of very rapid change in the organization and delivery of personal health services to patients. Much of this progress is the result of new developments in science and technology. These developments are causing profound effects on surgical care.

Surgeons are gratified to be at the forefront of clinical innovations that represent major improvements in the care received by patients in this country. Therefore, we believe it is important to weigh carefully the impact of any policy changes in the Medicare program, including changing payment incentives on the way surgery and medicine are now practiced, especially in view of new systems for the provision of surgeons' and other physicians' services in the future.

Many changes in the way health care is provided derive from changing payment practices by governmental and private third-party payers and from rising concerns about the overall costs of care. In the past, the American College of Surgeons was only minimally involved in these policy areas, but the College is now convinced that we must express our concerns about the impact of changing payment policies on the practice of surgery and medicine. The surgeon's relationships to hospitals, ambulatory surgical centers, health maintenance organizations, teaching and research centers are all being affected by the various incentives and disincentives incorporated into new payment methodologies. We have strong views about what incentives will make for good patient care at affordable cost; we have equally strong concerns that other interests of the patient may be adversely affected by inflexible or rigidly applied payment changes. In a word, Mr. Chairman, the members of the American College of Surgeons want very much to play a constructive role in your review of changes in payment policies under the Medicare program.

Our study of Medicare payment issues suggests that the first, highly critical step is to assure that a plan is fair to each of the parties concerned--patients, physicians and the government--by defining the services for which payments will be made. Payment for any service has no meaning unless everyone knows what is being provided. Similarly, the reasonableness of payment for any service cannot be ascertained until the content of the service is fully defined. This is a task to which the members of the College have devoted considerable thought and effort, and there should be no substitute for the use of surgical experts in the technical definitions of quality surgical care rendered to patients.

We believe that physicians as well as carriers clearly understand the content of many services and procedures now listed in the Health Care Procedure Coding System (HCPCS), which is used by the government to identify reimbursable services under Medicare. But not all services and procedures are so precise in their meaning. For example, certain visit codes fail to make their content clear to either practitioners or carriers and are subject to varying interpretaion. We think such codes should be carefully studied as part of any future payment policy changes adopted for the Medicare program.

We recognize as well that services or groups of services with discretionary content not easily verifiable on a case-by-case basis, such as the visit codes, account for sizeable portions of total expenditures for practitioner services under the Part B program. Therefore, better definition of the actual content of such services could have an important impact on spending for these activities.

For many years, the College has played a key role in emphasizing that surgical procedures include preoperative, operative and postoperative care. Segmenting the operative experience so that it involves multiple payees is not only contrary to the College's concept of surgical responsibility but can easily add significant and unnecessary expense. Although this "global fee" concept has been understood for many years it may admit of further, precise definition. We would welcome an opportunity to assist the government in devising improved definitions of surgical and other payment units for Medicare services.

We believe that we know how good surgery and medicine should be practiced today, and how technological changes are reshaping the way in which that care will be provided tomorrow. We say this even though we recognize and understand that the pricing of Medicare services is going to be performed by a public agency, and that patients, payers and other professionals all have a role to play in the design and implementation process related to any new policies.

The second purpose of our testimony is to set forth four principles we believe to be important in the design of any broadly acceptable payment reform plan. These principles are designed:

First, to avoid changes in payment methodology that would have undesirable consequences for beneficiaries from the standpoint of 1) loss of access to care, 2) compromises in quality of care, or 3) burdensome increases in beneficiary costs;

Second, to support the best practice of medical care as now provided and encourage continued improvements in clinical diagnosis and treatment;

Third, to make future costs or services more predictable and acceptable; and,

Finally, to provide for a system of administration that will assure effectiveness and fairness.

I. Avoid Undesirable Consequences for Beneficiaries

The principal purpose of Medicare is to provide beneficiaries with reasonable economic protection against certain health care costs. In establishing a new system of payment, there is danger that the government's costs for the program will be reduced by shifting the burden to the patient. This burden can be transferred directly in monetary terms or indirectly by making it more difficult for the patient to obtain access to high quality care. Unless caution is taken, there is the very real risk that two systems of care will be established--one for the privately insured and more affluent segments of the population and a second, less desirable one, for Medicare and other publicly sponsored patients. We would hope that such unfortunate results can be prevented.

We believe that the prospects for achieving the objective of beneficiary protection can be much improved by recognizing reasonable variations in the level of fees paid geographically as well as according to the skill level required by a given service or the skill level of the physician providing the care. But we recognize that excessive medical and surgical fees are a problem in some instances and that this is an issue that needs to be addressed.

II. Support the Best Practice of Medicine

Changes in physician payment policies should support the best practice of medicine. This means that the payment system should be adapted to the medical care system, rather than expecting the converse. Medical care practices are dynamic and changing continuously as knowledge grows and new technology becomes available. The payment system should be organized to permit changes in payment concurrently with changes in practice and to permit improvement in payment methods as experience with a new approach reveals problems and possibilities for advances. Above all, we are concerned that payment policies not impede the continuation of these improvements in clinical practice for which this country and American surgery are renowned. Unless great care is taken in the design of payment methods, advances in clinical medicine may inadvertently be seriously impeded.

III. Make Future Costs for Services More Predictable

The issues of changing costs of practice, productivity, technological and scientific advances, the quality of care provided and long-term effectiveness need to be taken into account in making payment adjustments. These issues are complex, but it seems possible to provide for reasonable limitations on the rate of increase in health care costs. Nevertheless, we do not believe in a mechanism such as DRGs for physicians.

However, combining services into appropriate units, as feasible, has always seemed desirable--not only to avoid incentives to increase the number of services, but also to permit patients to know ahead of time the costs of some of the major services they will receive. Today, most surgeons charge a fee for a surgical operation that includes a preoperative visit, the operation itself and visits after operation at least until discharge from the hospital. The College has supported for years this kind of "global" fee that packages the cognitive aspects of surgical care before, during and after the operation, including the operative procedure--all in a single fee. The important judgmental decisions made in the preoperative, operative and postoperative periods are best performed by surgeons. We would be pleased to share our experience in efforts to apply the packaging concept in the Medicare program.

IV. Provide for Effective Administration

The system of administration to be applied in the case of any new payment system is a key element for its acceptability and success. Changes that require the creation of entirely new organizations not only would require a lengthy start-up period, but also would introduce the risk that a new agency might not perform adequately. For example, we are concerned about suggestions for making individual physicians the organizers and payers for all of the complex services provided to patients. If the attending physician were assigned such a task, he or she would be required to perform large-scale administrative duties for which many physicians are neither equipped or inclined to assume responsibility. Moreover, such assignments could introduce conflicts among physicians in arranging for the best quality care for patients.

We also consider it highly important to provide for a smooth and orderly transition from the present payment system to any changed one. This would help avoid undue difficulties for both patients and physicians, because of administratively unrealistic burdens put upon those who receive and those who provide medical care.

Conclusion

In conclusion, Mr. Chairman, the American College of Surgeons wishes to re-emphasize its intention to offer assistance to the Congress in developing any revisions in Medicare physician payment policies and to the Administration in implementing any proposals that are adopted. To that end, the College is hosting a meeting of representatives of the major surgical specialties on March 7 and 8. The purpose of the meeting is to review some of the options for physician reimbursement reform that are being considered in the Congress and to discuss how these options would affect patients and the quality of their care, as well as the practice of surgery. The four major issues we will be addressing are:

- assistants at surgery
- fee variations
- defining units of reimbursable services.
- physician participation issues.

The comments we receive during the course of the meeting will be considered in the College's policy development efforts.

The American College of Surgeons understands that economic and budgetary concerns have been major factors in many recent policy actions under Medicare. We hope that together we can participate in finding methods to address these issues in ways that do not disadvantage patients or cause unneeded and disruptive strain on the medical system itself.

Thank you.

Mr. Coyne. Mr. Daub.

Mr. Daub. Thank you very much, Mr. Chairman.

I am familiar with the testimony I missed from the panel. I had a chance to hear some of it and read the balance.

Does anyone care to elaborate on a view that the Medicare Economic Index has failed to get its job done or to do its work?

Anybody like to comment on that? Would it be Dr. Nelson?

Dr. Nelson. Well, Mr. Daub, I think that the question of whether it has failed depends on what it was intended to accomplish.

Mr. Daub. Do you think it is an accurate measure of inflation?

Dr. Nelson. It certainly is not at this point, sir. If it was intended to provide a rational mechanism for having reimbursement keep pace with the increasing costs of practicing medicine, it certainly has not kept pace. This fact is pointed out by the broad discrepancy between usual levels of reimbursements for my Medicare patients and what my usual and prevailing fees are for my non-Medicare patients. This discrepancy then, leads to a cost shift to the young families that come to me, and they perceive this as being unfair.

Mr. Daub. Dr. Leffall, can you tell me if the college has any position with regard to the administration's proposal to rebase the Medicare Economic Index?

Dr. Leffall. No; but this is one of the issues that will be discussed this weekend. You know that is a broad issue, one that has many facets to it.

And in addition to the major items, that I had listed in my testimony, that is the one that is going to be discussed tomorrow and on Saturday in Chicago.

Mr. Daub. If you oppose that change, would you let this committee know of the college's specific recommendations with respect to how to save some money in other policy areas?

Dr. Leffall. I certainly would; yes, Mr. Daub.

Mr. Daub. Mr. Chairman, let me ask one other question that has been prepared—I think is a good one.

In anesthesiology, if the data is correct, the 1983 HCFA data, indicates that anesthesiologists refuse assignment in more than 50 percent of the cases. Does that suggest that the administration's standby proposal is likely to save the Federal Government money at the expense of increased beneficiary out-of-pocket expenditures?

Dr. McKechnie or Dr. Weiss?

Dr. Weiss. I would think it would. I do not know how correct that estimate——

Mr. Daub. The figures are; yes.

Dr. Weiss [continuing]. That participation is. I have no way of knowing that. But if there is a drastic change in reimbursement for that kind of anesthesia service, I would think that there must be a shift of costs in the patient's direction.

Mr. Daub. While I have all of you here, and with your interest in the matter, prior testimony suggested that in catastrophic cases we could have a part C or do something about these costs. Should it be the Government that does it, should it be a private sector responsibility, or should it be a combination of both?

Does anyone care to give us your thoughts, at least about the fast track that particular subject is on around here?

Dr. **Nelson**. Yes; I hate to say that we are about to come out with a major report and study, but—as a matter of fact—we are. The AMA is developing a report that looks at the entire system of funding Medicare going into the future. This report will provide our views on some of the questions that you were referring to earlier in your questioning about shifting the burden to future generations.

We will have a series of recommendations on how to provide more effective prefunding of Medicare costs and ways that we see to keep the system solvent as we move into the 21st century. The AMA also has positions on taking care of the underserved population, the medically indigent now, those who are falling through the cracks, and more adequate provisions for catastrophic coverage.

Mr. **Blehart**. Mr. Daub, let me add that the AMA does support catastrophic coverage as an element of all health insurance programs, including Medicare. And as far as how that program should be financed, for Medicare beneficiaries, there are a number of questions outstanding.

As to the actual expense of Secretary Bowen's proposal, which leaves the beneficiary liable for almost $1,000 in part A coinsurance, in the form of two part A deductibles, under current policies that are available through the Medigap market—which approximately two-thirds of the Medicare beneficiaries do indeed have. It is uncertain as to how it compares with the private sector.

We hope that the study that the adminstration has called for and the Secretary of HHS has indeed initiated, will address those issues. Until those questions can be answered, it is unclear as to what is the best method to assure Medicare beneficiaries of such catastrophic coverage.

Mr. **Daub**. I have no other questions, Mr. Chairman.

Mr. **Coyne**. Mr. Pickle.

Mr. **Pickle**. Thank you, Mr. Chairman.

Dr. Nelson, I would like to ask you some questions pertaining to the general physician freeze or to get a response from either of the other two physicians up here.

There has been a continuing freeze on physician charges, and if they stay in place now, as of this October, there will have been a 27-month freeze. And if we go forward, again, for another 12 months, that will be 39 months without any kind of additional consideration for physician fees.

Now when they first were put into place, there was some reason. The physicians accepted it because limitations were put on others. But as we go forward, it seems to me like they could just continue to freeze physicians and their charges and fees, and not the others. I think that is basically unfair and improper.

Now I want to ask you, if this freeze continues, what effect would it have on the access to care or the quality of care of beneficiaries? Would it have effect on the quality of care?

Dr. **Nelson**. I think ultimately it would have to have some impact on access, despite the fact that the American Medical Association continues to encourage all physicians to take care of patients at reduced rates, if that is indicated in that particular instance.

Nonetheless, as the discrepancy continues to grow between a physician's usual fees needed to cover his or her expenses increasing, and with the Medicare fee freeze prohibiting any contribution to covering those increased expenses from being fairly carried by the Medicare population, ultimately you would see a point where I would fear that access to care—in some instances, in some locations—would be reduced.

Mr. PICKLE. Would that also include the quality of care?

Dr. NELSON. The quality of care is perhaps impacted more by the changes in reimbursement to hospitals and that is being seen now in decreased staffing levels.

There are allegations that patients are being discharged "quicker and sicker." This may or may not be the case, but apart from that, certainly some services that we have come to rely on in the hospitals—a certain level of nursing staff support that we have come to rely on—in some instances we are seeing this curtailed because of the freeze.

Mr. PICKLE. Were you here this morning when Dr. Desmarais, I believe, said that the administration was not going to recommend another 12 month freeze, but they were going to recommend a change in the MEI index, that is medical indexing formula. And I was contending that because they do not know how many people are above or below the participating level, that in effect they were taking away the freeze but—they were giving the freeze relief but adding to it on the other end, that it was a kind of a washout.

Were you here for that testimony, this morning?

Dr. NELSON. Yes, sir.

Mr. PICKLE. Would you comment on that? Am I generally correct or is my assumption without foundation?

Dr. NELSON. As we calculated, with the retroactive application of the MEI adjustment, it comes out pretty much a wash.

Mr. PICKLE. So it is really not much of a relief, or very little?

Dr. NELSON. As we calculate it—0.8 of 1 percent—as you said, that is not very much relief.

Mr. PICKLE. Well, let me ask you another question. How does Medicare's payments compare with payments of other third-party payers, that is, commercial-type of payers? Does Medicare pay as much as the other payers?

Dr. NELSON. No; it does not, generally, and it is because the reimbursement levels have been artificially held down for over a decade. So that there is, in many parts of the country and for many practitioners, a dual standard, two-tiered system, insofar as the fees that are charged and the reimbursement that is received.

Mr. PICKLE. Is Medicare's payment rate, then, falling further behind, as compared to the third-party payers?

Dr. NELSON. Yes, sir. It depends on whether we are talking about a rural area, an urban area, and whether the physician voluntarily froze his or her fees for a longer period of time, or whether he or she started out with lower fees in the beginning. And so, it is variable. It is safe to say that there is a substantial discrepancy between those reimbursement rates, Medicare has fallen further behind.

Mr. PICKLE. Well, why is there such a wide variation of participation between States? States, in some sections of the country, like the Northeast or the Midwest, have a very high percentage of participation of physicians. And yet, in my part of the country, it is just almost the opposite. I think Texas had about a 16-percent rate of participation.

Now we care just as much about giving good medical care as any other State, in any other region. More so, I would say. And yet, we only have a 16-percent participation rate and some of the States in the Northeast have four or five times higher.

Now why is that?

Dr. NELSON. Well, I would have to say that there must be multiple factors, including philosophic objection, and the nature of the patient population that a physician serves.

I think it is important to note that there is probably less variability in the number of claims that are accepted on an assigned basis. We know of some physicians who are nonparticipating physicians, even though they accept assignment on all of their patients, simply because they are philosophically opposed to signing a participation agreement. They want the right to accept assignment on a case-by-case basis, when patients need it.

And the fact is, that the percentage of assigned claims is about two-thirds of the total claims are on an assigned basis, even though only about 30 percent of physicians have signed the participation agreement.

Why it varies from State to State? It probably depends on many factors, including just the philosophical attitudes of the physician in a particular area.

Mr. PICKLE. I would be glad to hear from anyone else on that or any of the other questions.

Mr. BLEHART. I just wanted to add to Dr. Nelson's comment that although the participation rate in the State of Texas—that is, the number of physicians who are participating physicians—may be lower than other States, the rate of assignment in the State of Texas is certainly well over 50 percent, according to HCFA's statistics. Indeed nonparticipating physicians in Texas take over 45 percent of their claims on an assigned basis.

So overall, the state of Texas, in the period of July through September, shows a 58 percent rate of assignment of claims for physician services.

Dr. NELSON. That sort of backs up what I was saying.

Mr. PICKLE. Yes, and I am glad they do participate. And there has also been charges made that physicians, if you did not take assignment, they are going to gouge the patients. And I think the study that will be distributed later shows that that is not the case, that they are still taking assignment and still handling the majority of the cases, even though they may not be under assignment.

But it is disturbing to the average person to make an evaluation. Why would one state just not care to go that route and another section—I think traditionally because they were sort of a quasi-public agency to start with, in some respects, and they have just continued on with it over the years.

But there must be a reason for it.

Do any of you other physicians care to comment about the possibility of if the freeze continues, would it affect access or would it affect quality care?

Dr. **Weiss**. I would just like to toss in the recent events that are continuing in my home state, in Massachusetts, particularly with regard to obstetrics and orthopedic surgical care. You are aware of the situation that exists in our State with regard to limitation of reimbursement by all third-party payers, which when combined with increasing malpractice insurance costs, has created an impossible situation for many of the higher risk specialists in our state.

And there is no question about the fact that access to care by large groups of patients is beginning to be affected and will continue to occur until some solution to this overwhelming problem is developed.

I recognize that our state is different, in many ways, from other States and I am sure you are all aware of it.

But the fact is, that we now have physicians who are leaving the State, and there are numbers of them in various specialties who are doing it because the practice environment is so inimical to them that they no longer will tolerate it.

And maybe they are all going to go to Texas, I do not know.

Mr. **Pickle**. I have got a feeling that a number of them have.

Mr. **Daub**. Would the gentleman yield on this point?

The question is certainly valuable and the answer probes a concern I have, which is the whole area of what we do with respect to the insurability.

This whole idea of how we reinsure the risks that are being taken by those who want to practice. And let us say in your case, as a panel, defensive medicine relative to activist lawyers and courts and insurance companies who cutthroat their premiums to just get business on the books so they do not charge you the right premium. And a whole combination of reasons.

Leading you all to a pretty serious dilemma and that is how do you pass on the cost of a heart surgeon in New York City whose premium is $101,000? You know who is going to pay for that?

Dr. **Weiss**. In Massachusetts, we cannot pass on the cost. That is the problem. This does not exist, even in New York. We either have to pay those increasing premiums or leave the State, or modify our practices in such a way that we are not exposed to that kind of risk.

I might also mention the fact that there are solutions. For example, I am at a Harvard Teaching Hospital. As you may know, Harvard University has set up an insurance plan that covers all the Harvard Teaching Hospitals with regard to liability. Just a week ago, as anesthesiologists, we were reclassified on the basis of a 5-year experience in our hospitals, from class 5 to class 4 with resulting savings of $5,000 per physician in malpractice insurance costs.

There are ways of altering this environment but it is an awfully difficult thing to bring about.

Mr. **Daub**. Does anyone else have any comment on defensive medicine and the cost shift in Medicare and those things that get squeezed by it?

Dr. **McKechnie**. I would like to mention that our society started a while back a committee on standards. We also have a committee on patient safety. We are hoping that both of these committees will develop standards of care for patients under anesthesia, that will help to lower the cost of our liability insurance.

We had the same experience in Florida when we put a rider on our insurance that required certain things had to be done to the patient under all conditions. Within a year and a half, we also dropped from five down to four and we are hoping to drop eventually down to three.

There are ways of accomplishing some favorable change without recourse to regulation.

Dr. Leffall. Mr. Daub, the American College of Surgeons is certainly concerned about these issues, access to care, the increasing use of defensive medicine and the fact of the fees being frozen, the increased costs cannot be passed on. These are some of the issues that will also be discussed this weekend to see what we can do to try to find some of the answers to these very difficult problems.

Mr. Daub. I thank my friend, Mr. Pickle, for yielding. He will be right back. You don't get a chance very often around here to be chairman of the subcommittee. Let's conduct a little business while we are at it.

Does anybody else have anything to say on medical malpractice insurance? Does the AMA want to talk about their bill? [Laughter.]

Dr. Nelson. Thank you, Mr. Chairman.

We certainly are pushing as hard as we can to find answers to this and it goes beyond dollars and cents. It involves the quality of care, the mentality of physicians operating in a circumstance in which they really can't be as effective when they are always fearful that the next patient may sue them, and it has to do with access to care—such that on the Island of Mokauea in Hawaii, where none of the physicians are delivering babies. Pregnant women have to be flown to larger islands.

We are seeking solutions. We appreciate your question.

Mr. Daub. I am interested in the general liability issue, for your information. I find it difficult to be a cosponsor of the medical bill that is here, not because I am not concerned about some limitation but I am looking at 50 State tort law, looking at the idea that the truckers will want one kind of approach federally, the physician another kind of approach, if any, federally. There is a whole variety of problems.They all go back into the reinsurance question, in how you pool all this. Most of it has gone offshore. Physicians and truckers are thinking about starting their own captives. Many medical groups have done that. You can't get coverage for midwife type care. If the doctor won't deliver the baby and you can't get coverage for midwife, if it is a noncomplicated delivery, you have a whole series of problems.

I am interested in trying to do something that sets standards and streamlines the procedure by which we dispose of these questions, from toxic tort to intervening surgical questions of malpractice, and trying to do something and introduce a bill that I think solves a lot of our problems without 60, 80 or 200 new Federal liability laws from airlines to nuclear damage to other things.

I appreciate your concern. I was thinking about Massachusetts a little bit ago and wondered if all these adverse conditions might lead one to believe there is a shortage of physicians in Massachusetts. I don't know.

Dr. Weiss. I don't think there is.

Mr. Daub. Thank you. Mr. Chairman, I appreciate the chance to visit with these fine witnesses.

Mr. Pickle. Thank you very much for your testimony.

Our next panel will be a panel on reimbursement to other providers. I am going to ask Dr. John Newmann, Dr. Edward Berger, and Margaret Cushman come forward.

While they are coming forward, I want to recognize the fact that Dr. Charles Vanik, a former member of the committee, has been observing our hearings this morning. We are pleased to have him here with us. His presence means a great deal to us.

The Chair is also going to ask Alan Spielman to come up. He is the executive director of Government relations for the Blue Cross & Blue Shield Association. Mr. Spielman, we are going to ask you to be a part of the same panel. This will be the last panel.

Our first witness will be Dr. John Newmann, representing the National Association of Patients on Hemodialysis and Transplantation. The next witness will be Dr. Edward Berger, representing the National Medical Care, then Margaret Cushman, executive vice president, Visiting Nurses and Home Care, Inc., representing the National Association for Home Care, and then Alan Spielman, executive director of Government Relations, Blue Cross & Blue Shield Association.

We will first recognize Dr. Newmann. We would ask you all to stay within the time constraints.

STATEMENT OF PAUL FEINSMITH, PRESIDENT, NATIONAL ASSOCIATION OF PATIENTS ON HEMODIALYSIS AND TRANSPLANTATION, PRESENTED BY JOHN NEWMANN, PH.D., IMMEDIATE PAST PRESIDENT

Mr. Newmann. Thank you, Mr. Chairman.

Mr. Paul Feinsmith, the president of the National Association of Patients on Hemodialysis and Transplantation has asked me to present his testimony.

Our organization represents kidney disease patients and their families, all of whom owe a profound debt for the existence of the ESRD program and to the members of this committee. Mr. Feinsmith and I are both patients and have been on home hemodialysis for 13 and 14 years respectively. Home dialysis is a treatment option that has made it possible for us to continue to maintain our professional careers, his as a practicing attorney and mine as a health policy and management consultant.

I will try to read excerpts of my testimony knowing that we have all been here a long time.

We appreciate the opportunity to appear before you today, in no small measure, because your stewardship of the program over the years has been largely responsible for its success. I would like to emphasize it has been an extraordinarily successful health care program both in achieving its life saving social goals and in the realization of economic efficiencies.

Virtually every kidney patient in the United States today whose kidneys have failed now has access to essential life sustaining treatment without having to exhaust personal and family resources. The rate per dialysis treatment paid by Medicare today is

67 percent lower, adjusting for inflation, than at the program's beginning in 1973.

As technology has improved, costs have decreased. No other health care program comes close to this record. The increase over the years in total program expenditures is attributed almost wholly to the growth in the population served or perhaps I should say saved, from approximately 8,000 in 1973 to over 80,000 today.

Our purpose in appearing here today, Mr. Chairman, is to provide our recommendations on how best to assure the continuing successful cost-effective operation of this program. We believe the administration's budget proposals to reduce provider reimbursement under the program and to eliminate the ESRD networks will have adverse effects on patients in the program by reducing access to needed services, undermining efforts to assure quality of care, eliminating the one mechanism which enables patients to air and resolve grievances about the performance and delivery of services, and severely damaging the possibility of promptly establishing a national consolidated ESRD data system which alone can provide the basis for responsible planning and monitoring of the program.

We believe there are three issues this subcommittee should focus on; the need to proceed cautiously with any changes in provider reimbursement that would have the effect of reducing access to care or compromising quality of care; the need for a national consolidated ESRD data system; and the need to clarify the role of the ESRD networks, both as participants in the national data system and as a mechanism for protecting patients' access to care and enforcing quality standards.

The regrettable fact is that despite the substantial expenditures made for this program since 1973, there is no consolidated national data system collecting information on patients or the outcome and complications of treatment. This failure is not the fault of Congress. The statute directed HCFA to establish a medical information system and to provide detailed annual reports to Congress.

After several changes, HCFA finally, in 1980, delegated data responsibilities to the ESRD networks. Now in 1986, various elements of a national data system exists but are not coordinated. These include among them the data collection activities of the ESRD networks, without which there would be no reliable national outcome data at all, and a variety of other specialized and limited data registries.

We as patients need such a system because it is the only way we can get the data to make informed choices about alternative therapies. You as guardians of the public's conscience and purse need such a system to make sound judgments about the allocation of resources.

The Congress created the ESRD networks to perform several functions, including quality assurance, the resolution of patient grievances and the promotion of patient rehabilitation. The administration in its annual crusade to dismantle the networks, never mentions these activities, but they are central to the security and well-being of patients. Patients are represented on network executive committees and medical review boards, both of which often serve as ombudsmen as well as forums for discussion.

Reimbursement issues are of concern to patients for one reason and one reason only. The reimbursement mechanism must not introduce incentives that result in disruption in access to services or undermine the quality of care. Quality of care is not rhetoric for us. Dialysis is lifetime care, three times a week, every week of our lives. Each treatment exposes us to major risks of infection, complications, and death. It is a therapy that requires the utmost care, precision, and sensitivity, not just once in a while, but every time. We are most attentive to access and quality issues.

Thus, we believe HCFA's current proposals to reduce facility reimbursement require careful scrutiny. Dialysis facilities have already achieved substantial economies. They were implemented as a result of the August 1983 reduction in reimbursement rates. It cost approximately 8 percent less per dialysis treatment today than it did in 1973.

We are concerned that the effect of pressures to find additional savings will reduce both access and quality. Lives are being saved by this program and may be at risk with further funding cuts.

HCFA has always evaluated costs inappropriately assuming quality of care and outcomes are unchanged. The medical information system does contain mortality and in-patient hospitalization cost data. We suggest HCFA compare the mortality and hospitalization costs of dialysis for the 2 years, 1981 and 1982, before the 1983 cuts, with those of 1984 and 1985 following the reduced rates. It is important to know if there were any changes in patient mortality or morbidity, after the rates were lowered.

The data exists to evaluate this. It seems unconscionable not to do so prior to making reimbursement rate changes.

Similarly, we urge your careful examination of the proposal to restructure the physician capitation payment.

Mr. Chairman, we are confident this committee will pursue its deliberations with the same care and wisdom it has displayed in the past and we stand ready to provide the staff with whatever information and assistance we can.

Thank you.

[The prepared statement of Paul Feinsmith follows:]

NAPHT
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TESTIMONY OF PAUL FEINSMITH
NATIONAL ASSOCIATION OF PATIENTS ON HEMODIALYSIS AND TRANSPLANTATION

Mr. Chairman, Mr Paul Feinsmith is unable to present his testimony as President of the National Association of Patients on Hemodialysis and Transplantation, more commonly known as NAPHT. My name is John Newmann and I am the Immediate Past President of NAPHT and have been asked by Mr. Feinsmith to present our testimony. NAPHT is an organization representing kidney disease patients and their families, all of whom owe a profound debt of gratitude to the members of this committee for the existence of the ESRD program. Mr. Feinsmith and I are both patients and have been on home hemodialysis for 13 and 14 years respectively. Home dialysis is a treatment option which has made it possible for us to continue to maintain our professional careers, his as a practicing attorney,mine as a health policy and management consultant.

We appreciate the opportunity to appear before you today, in no small measure because your stewardship of the program over the years has been largely responsible for its success. And I want to emphasize that it has been an extraordinarily successful health care program, both in achieving its life saving social goals and in the realization of economic efficiencies. Virtually every ESRD patient in the United States now has access to essential life sustaining treatment without having to exhaust personal and family resources. The rate per dialysis treatment paid by Medicare today is 67 per cent lower, adjusting for inflation, than at the program's beginning in 1973. As technology has improved, costs have decreased. No other health care program comes close to this record. The increase over the years in total program expenditures is attributable almost wholly to the growth in the population served--or perhaps I should say saved-- from approximately 8,000 in 1973 to over 80,000 today.

Our purpose in appearing here today, Mr. Chairman, is not just to commend the Committee, but to provide our recommendations on how best to assure the continuing successful, cost effective operation of the program. We believe the Administration's budget proposals to restructure provider reimbursement under the program,and to eliminate the ESRD Networks-- and thereby dismantle much of what currently exists in the way of of program data collection--will have adverse effects on patients and the program by:(1) reducing access to needed services;(2)undermining efforts to assure the quality of care;(3) eliminating the one mechanism which enables patients to air and resolve grievances about the performance and delivery of services; and (4) severly damaging the possibility of promptly establishing a national consolidated ESRD data system which alone can provide the basis for responsible planning and monitoring of the program.

NAPHT believes there are three issues this subcommittee should focus on: (1)the need to proceed cautiously with any changes in provider reimbursement that could have the effect of reducing access to care, or compromising quality of care; (2) the need for a National consolidated ESRD data system;and (3) the need to clarify the role of ESRD Networks,both as participants in national data system and as a mechanism for protecting patients access to care and enforcing quality standards.

The regretable fact is that despite the substantial expenditures made for this program, there is no consolidated national data system collecting information on patients or the outcome and complications of treatment. This failure, I hasten to add, is not the fault of Congress. The Congressional policy spelled out in the statute directed HCFA to establish a medical information system and to provide detailed annual reports to the Congress. Such a data system was initially attempted by HCFA through a private contract with Value Engineering, Inc. After that failed HCFA attempted to collect the data directly from facilities. This too resulted in failure. In 1980 HCFA delegated data responsibilities to Networks. Now in 1986, various elements of a national data system exist but are not coordinated. These include, among them, the data collection activites of the networks, without whom there would be no reliable national data at all; and a variety of other specialized and limited data registries. In short, what we have are bits and pieces which need to be pulled together into one coordinated system. We as patients need such a system because it is the only way we can get the data to make informed choices about alternative therapies. And you, as guardians of the public's conscience and purse, need such a system to make sound judgements about the allocation of resources.

The Congress created the Networks to perform several functions, including the encouragement of lower cost modalities of treament, quality assurance, the resolution of patient grievances and the promotion of patient rehabilitation. The Administration, in it's annual crusade to dismantle the networks, never mentions these activities. But they are central to the security and well being of patients. Elimination of the Networks would have devastating consequences for patients. The Networks provide the only means through which patients can obtain data and information about treatment options, resolve patient care problems, and contribute their experiences to the development of patient care standards. Patients are represented on Network Executive Committees and Medical Review Boards, both of which often serve as "ombudsmen" as well as forums for discussion. And since the Networks have established relationships with the providers they could play a vital role in expediting a national data system. If there is some disatisfaction with their performance, much of the criticism should be directed at HCFA, which through neglect, has forced Networks to work in a policy vacuum.

Reimbursement issues are of concern to patients for one reason, and one reason only: that the reimbursement mechansim does not introduce incentives that result in disruption of access to services or undermine quality safeguards. Quality of care is not rhetoric for us. Dialysis is lifetime care;three times a week, every week of our lives. And each treatment exposes us to major risks of infection, complications and death. It is a therapy that requires the utmost care, precision,and sensitivity--not just once or once in a while, but every time. So we are most attentive to access and quality issues.

Thus we believe that HCFA's current proposals to curtail facility reimbursement require careful scrutiny. In this attempt to ratchet down payment rates HCFA assumes that dialysis facilites should realize ever greater savings by reusing dialyzers and resorting to the use of less qualified staff. And if they can't do that-"exit the market place". But these presumed cost saving measures are issues of great contention among professionals and patients alike. They are quality issues that should not be dictated arbitrarily by a reimbursement method. Dialysis facilities have already achieved substantial economies. They were implemented to the extent possible as a result of the August 1983 reduction in reimbursement rates. It cost approximately 8 per cent less per dialysis treatment today than it did in 1973. We are concerned that the effect of pressures to find additional savings will reduce both access and quality.

Government funding for the ESRD program is quite different in purpose than funding for many other programs. Since lives are at stake, it is most appropriate to evaluate costs and patient outcomes over time. HCFA has always evaluated costs, inappropriately assuming quality of care and outcomes are unchanged. HCFA's Medical Information System does contain mortality and in-patient hospitilization cost data(the former sent by ESRD Networks, the latter by Medicare intermediaries). We suggest that HCFA compare the mortality and hospitilization data of dialysis patients for the two calendar years, 1981 and 1982(prior to the August 1983 decrease in ESRD reimbursements), with the two calendar years 1984 and 1985 following the reduced rates. It is important to know if there were any changes in patient mortality or morbidity after the reimbursemt rates were lowered. The data exists to evaluate this, and it seems prudent to do so prior to making reimbursement rate changes. Just as other government funded programs are properly subjected to evaluation, this one should also be evaluated before changing the funding for its future.

We ask this Committee to require HCFA to monitor levels of morbidity and mortality in the ESRD program. Are we going to witness continual reimbursement rate reductions until the data show decreased quality of care through increased morbidity and mortality? Cost is controlled by the established Medicare reimbursement rate which has decreased since 1973, contrary to all other Medicare programs. In evaluating the appropriate level of the ESRD reimbursement rate we trust this Committee will not only encourage HCFA to keep these issues in mind, but will use current 1985 cost data to estimate the true cose of ESRD treatments. Obviously Congress and HCFA will be unable to evaluate the outcome of the ESRD program if we do not have a consolidated National Data system.

Similarly, we urge your careful examination of the proposal to restructure the physician capitation payment. We think you will want to consider the potential effect of this proposal on the Congressional policy of encouraging the use of lower cost modalities, particularly home dialysis.

Mr. Chairman, we are confident this committee will pursue its deliberations with the same care and wisdom it has displayed in the past. We stand ready to provide the staff with whatever information and assistance we can.

Mr. PICKLE. Thank you, Dr. Newmann. The next gentleman, Dr. Berger.

STATEMENT OF EDWARD E. BERGER, M.D., DIRECTOR OF REGULATORY AFFAIRS, NATIONAL MEDICAL CARE, INC.

Dr. BERGER. Thank you, Mr. Chairman.

National Medical Care is a major national provider of kidney dialysis services. The present budget proposes a 6- to 8-percent cut in the basic dialysis reimbursement rate. We believe a cut of this magnitude would have a destructive impact on the system of services that have developed through the history of the ESRD Program and on patients' access to care.

I would like to explain our reasons for believing that in three basic points.

First, there is the nature of the data used by OMB to arrive at its recommendation. The cost data used by OMB are 4 years old. They do not take account of the changes in facility operations and economies which were achieved pursuant to the 1983 reimbursement reduction. They also do not take account of the inflation in the cost of labor, rents, water, and other utilities that have been quite considerable in those years.

It is unclear how HCFA can have any clear sense of the relationship between these 1982 costs and the real present operating costs of dialysis facilities. I don't believe that OMB has any clearer picture, yet they are proceeding to make a recommendation based on these outdated costs.

OMB also relies on a statistical weighting mechanism which gives extra influence to the costs of the larger and more efficient dialysis facilities in arriving at its proposed rate. This is a statistical manipulation which was specifically rejected by HCFA when it set the current composite rate in 1982, and I think that there is a very good reason for that.

HCFA looked at these same 1982 facility cost data in 1984 and again in 1985 to see if a rate revision was justified. Its conclusion in both of those years was that no rate change was justified on the basis of 1982 costs. I think there is very good reason to believe that the entire recommended 8 percent cut in the present budget is a result of this discredited statistical manipulation.

Second, the impact of the proposed cut would be much broader than OMB would have us believe. OMB plans that small and inefficient dialysis facilities will close as a result of this proposal. That is one of the sources of savings.

HCFA data for 1984 indicate that when you consider total patients, facility and home, 36 percent of all dialysis facilities in the United States had 35 or fewer patients. If you count only in-facility patients, 45 percent of all of the facilities treating chronic hemodialysis patients have 35 or fewer patients as of the end of 1984. These are the small, inefficient facilities which OMB is targeting for closure.

Third, there are no real options in the face of a cut of this magnitude for either dialysis facilities or their patients. Most of the available operating economies have already been taken by dialysis facilities in response to the 1983 reimbursement cut, which was larger than 8 percent, on the average.

There is little or no excess treatment capacity in the dialysis system today. Health planning and certificate of need laws have always restrained capacity development through the history of the program, and the rate of new capacity development since 1981 has lagged significantly behind the rate of beneficiary population growth. So I don't think we can look to absorption of displaced patients into present excess capacity as a solution to the problem.

If OMB is setting a rate which it knows will cause present facilities to have to close because they cannot operate, how can they possibly look to new investment as a solution to the problem.

And finally, OMB says that the rate exception process will be there as the final backstop that will save the system. Well, it was the rate exception process that led by 1982 to a median per-treatment reimbursement in hospital facilities of $175, and many hospital facilities at over $250, and that caused the entire rate reform and the introduction of the composite rate only 2½ years ago.

Reliance on the exception process will be a gigantic step backward in dialysis reimbursement and will weaken all of the cost-control incentives that were built into the 1983 reforms.

We would propose that the OMB budget be rejected as it applies to the ESRD program; that the rate be frozen pending an audit and examination of timely 1985 dialysis facility cost data so that a fair reimbursement level based on current and timely operating cost information be established; and finally, that the Congress look very, very carefully at the way in which the ESRD program, as a very important and extraordinarily successful exemplar for catastrophic illness insurance, could help serve as the basis for and then be merged into a comprehensive catastrophic plan which would preserve the very real and substantial virtues of the present service delivery system and be even more cost effective and economical.

Thank you.

[The prepared statement follows:]

UNITED STATES CONGRESS

HOUSE OF REPRESENTATIVES

COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

STATEMENT OF NATIONAL MEDICAL CARE, INC. CONCERNING THE 1987 BUDGET PROPOSAL FOR MEDICARE'S END STAGE RENAL DISEASE PROGRAM

March 6, 1986

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STATEMENT OF NATIONAL MEDICAL CARE, INC. CONCERNING THE 1987 BUDGET PROPOSAL FOR MEDICARE'S END STAGE RENAL DISEASE PROGRAM

Background

In 1972, Congress created Medicare's End Stage Renal Disease (ESRD) program to guarantee health services to Americans with otherwise fatal kidney disease, and to protect them and their families from the catastrophic medical costs associated with the disease.

Chronic hemodialysis became a viable lifesaving therapy for ESRD victims in the 1960s, but the costs of treatment were prohibitive for most individuals or families. Coverage of chronic hemodialysis through private health insurance was rare, and premiums in the private sector would have been unaffordable. Because so few people could pay for services, dialysis treatment capacity was seriously constrained, and local committees were required to choose among applicants for treatment.

Our best working model for a more comprehensive catastrophic illness insurance program, the ESRD program has been successful in meeting every one of its goals:

- It has fostered the development of a national network of dialysis facilities adequate to meet the nation's treatment needs.
- The population on chronic dialysis has grown from barely 10,000 in 1973 to more than 80,000 in 1985. Additional thousands have received successful kidney transplants under program auspices.
- At the program's inception the dialysis population was predominantly young, male and white, with well above average education and income. Today, it is a representative cross-section of the American people, with every age, economic and racial group represented in proportion to the prevalence of the disease. (Table I)
- Quality of medical services provided within the ESRD program has been uniformly high throughout the program's history, and there have been important advances in both chronic dialysis techniques and the clinical management of kidney disease. The program has developed effective mechanisms for oversight through facility surveys and

certification processes without stifling the independence and creativity of both proprietary and voluntary providers of services.

The ESRD program has accomplished all of this, and at the same time has established *a record of cost control and efficiency unparalleled anywhere in health care*. Total program cost increases since 1973 are almost wholly attributable to growth in the beneficiary population. The program also has had to pay for the substantial increases in hospital and some other health care costs. But a dialysis treatment, the basic unit of service provided to ESRD beneficiaries, costs less today than it did in 1973. (Table II)

The per-treatment dialysis reimbursement rate was actually *lowered* in 1983. Independent facilities absorbed an 8% decrease that year, from $138 per treatment to $128. The decrease to hospital facilities was effectively much greater, as many had previously received cost-based rate exceptions. The average hospital reimbursement declined in 1983 from $175 per treatment to $132. Today's independent facility rate, for a treatment which is in fact a more comprehensive unit of service, is equivalent (after adjusting for the CPI-Medical) to $43.69 in 1973 dollars.

The OMB Budget Proposal

Despite the ESRD program's unique success in cost control and effective service development and delivery, OMB proposes a further 6-8% decrease in the dialysis reimbursement rate. It arrives at a new rate by using 1982 facility cost data and a new computational formula which gives added weight to the costs of large facilities which enjoy economies of scale. OMB predicts that small, less efficient facilities unable to streamline their operations will be forced to "exit the dialysis market" (close down), but relies on improved efficiency, excess existing capacity, new investment, and the rate exception process to maintain patient access to services.

OMB's proposal is almost willfully ignorant of the history and structure of the dialysis service system, and will have a destructive impact on that system.

The 1982 data used by OMB for its calculations are inadequate to assess the real present costs of dialysis providers. The data will be 4 years old when a new rate becomes effective, and antedate the 1983 rate revision. Facilities have, in the intervening years, had to adapt to the new reimbursement levels, far more restrictive rate exception standards, and (for hospital facilities) the implementation of the hospital Prospective Payment System. There have also been substantial real increases in such cost factors as labor, rent, water and utilities. A revised rate should be based upon more recent data.

The proposed rate reduction is the product of statistical manipulation - the new method of weighting cost data - rather than any cost reductions documented by the 1982 data. These same data were reviewed by HCFA in early 1984, and no rate reduction was proposed.

The effects of the proposed rate reduction on beneficiary access to services would be substantial. According to HCFA data, as of December 31, 1984 more than one third of ESRD facilities (35.7%) served 35 or fewer total patients. (Table III) If we consider only in-facility patients, fully 45% of all facilities fell below that size threshold. These are the small facilities, unable to realize economies of scale, which OMB would force to close - a critically large segment of the dialysis service system. Their present patients would have few options.

First, dialysis facilities, under severe economic pressure from the substantial rate reduction implemented in 1983, have already realized available operating economies, and cannot be expected to reap further savings from the same sources. Dialyzer reuse, more efficient staffing patterns, overhead reduction and similar economizing measures have already been exploited. Industry experts agree that home dialysis will not yield substantial additional savings. Many facilities are already at the minimum cost consistent with safe and effective services.

There is little or no excess treatment capacity in the system at present. Capacity has always been subject to fairly stringent restriction by State Certificate of Need and health planning agencies. Since 1982, dialysis station growth has lagged substantially behind beneficiary population growth, and there are indications in several states of unmet demand for capacity expansion. (Table IV) Furthermore, because economic forces have already produced facility consolidation in many areas, these small facilities tend to be relatively isolated, and many are sole community providers.

The rate of return on invested capital for dialysis facilities is barely high enough to sustain present investment levels. A further reimbursement reduction of 6-8% will make new investment impossible and will lead to substantial disinvestment as capital is transferred to areas which allow a reasonable rate of return. A very efficient facility operating on a margin of 12% will, under the OMB proposal, be reduced to a 4% pre-tax return, too low to support continued investment. New investment cannot be expected to pick up the slack caused by closed facilities.

Reliance on the rate exception process would be an enormous step backwards in dialysis reimbursement, and would effectively destroy the cost control incentives built into the present reimbursement system. In 1982, when exceptions for reason of high costs were easy to get, many hospitals were being paid more than $250 per treatment, and hospital facilities averaged a $175 reimbursement rate. Reintroduction of the earlier policy towards exceptions would threaten to wholly neutralize OMB's expected savings from the proposed rate reduction.

An Alternative Proposal

Elimination of the Federal budget deficit is an important national priority, and no program should be exempt from the most careful scrutiny. However, the ESRD program is unique in its:

- substantive achievements;
- absolutely unequalled record of cost control and efficiency; and
- experience of a significant rate decrease only two and one-half years ago.

It should be required to continue to seek new economies, but it should not be subject to ill-considered and potentially destructive cuts such as those proposed by OMB.

An alternative approach, which recognizes the program's past achievements, its present circumstances, and its importance as an exemplar of catastrophic illness insurance, would entail:

1. A reimbursement rate freeze pending a complete and accurate analysis of present service delivery costs and the impact of rate changes on the service delivery system.

2. An analysis of 1985 facility cost report data (and other appropriate and timely financial data) to assess the real present operating costs of dialysis facilities and the adequacy of the present reimbursement rate. These cost data will be in the hands of Medicare's fiscal intermediaries at the end of the present calendar quarter. They can be used to establish and implement a fair and efficient reimbursement which will preserve the existing service system by the end of the calendar year.

3. ESRD program reforms which more effectively control total Federal expenditures while preserving and expanding catastrophic illness benefits which are central to evolving policy initiatives. There are a variety of alternatives which are consistent with past and present Congressional and Administration proposals for Medicare reform, and which would further the development of a cost-effective partnership between government and the private sector in the financing and delivery of health services to Medicare beneficiaries.

The ESRD Program as a Model For Catastrophic Illness Insurance

The ESRD program provides one successful organizational model for the development and implementation of Catastrophic Illness Insurance. Careful study of the program can help in the design of a more extensive catastrophic coverage plan, either for Medicare beneficiaries or for a broader population segment. But past program success does not guarantee the continued stability or viability of the program. Maintenance of the delicate balance between service price and treatment capacity is absolutely essential to the ESRD program's continued success.

That crucial balance is threatened during present efforts to achieve program economies. The ESRD program should not be immune to close and precise economic scrutiny, and if economies can be realized without harming the effectiveness of the program they should be implemented. But to disrupt the ESRD program at this time on the basis of inadequate or incomplete financial data, to destabilize the service delivery system with the result of closing facilities or denying care to some who need it, would contradict the Nation's basic commitment to catastrophic coverage, and would dismantle our best exemplar of how such coverage can be organized, funded and administered.

Table I

CHARACTERISTICS OF DIALYSIS PATIENTS, 1967-1978

Characteristic	1967	1978
% Female	25.0	50.8
% Black	7.0	34.9
% > 55 yrs.	7.0	45.7
% Married	79.0	61.8
% College Grad.	25.0	7.5

Data adapted from Evans, Blagg, and Bryan, "Implications For Health Care Policy", JAMA, Vol. 245, no.5, February 6, 1981.

Table II

ESRD PROGRAM - BENEFICIARY POPULATION AND REIMBURSEMENT RATE

Year	ESRD Patients	CPI Medical	Rate Per Tmnt	Rate Adjusted For CPI Medical
1973	10,000	137.7	$ 138.00	$ 138.00
1975	22,674	168.6	138.00	113.11
1977	34,778	202.4	138.00	93.88
1979	50,829	239.7	138.00	79.31
1981	68,288	294.5	138.00	64.49
1983	81,873	357.3	128.00	49.42
1985	(97,000)	403.1	128.00	43.69

Patient count of all living ESRD patients as of July 1 of each year, includes dialysis, transplant and post-transplant patients. Estimate for 1985 based upon 9% annual growth. HCFA, Bureau of Data Management and Strategy. CPI from Bureau of Labor Statistics

Table III

SIZE OF U. S. DIALYSIS FACILITIES - 1984
BY TOTAL PATIENTS (INCENTER AND HOME)

Total of Facilities with at least 1 patient = 1290.

Facility Size No. of Patients	Facilities In Group	Total % of Facilities This Group Or Smaller
1 - 10	93	7.21%
11 - 20	145	18.45%
21 - 30	147	29.84%
31 - 40	170	43.02%
41 - 50	132	53.26%

HCFA data from ESRD Facility Survey, 1984

Table IV

DIALYSIS CAPACITY EXPANSION, 1981-84

Year	Percentage Increase In		
	Patients	Facilities	Stations
1981	12.53%	10.52%	11.80%
1982	11.61	4.85	4.74
1983	9.46	5.46	7.40
1984	9.02	4.70	7.02

HCFA data from annual Facility Survey Tables and ESRD Provider Listing

Mr. PICKLE. Thank you.

Now Margaret Cushman, if you will proceed, please.

STATEMENT OF MARGARET J. CUSHMAN, R.N., EXECUTIVE VICE PRESIDENT, VISITING NURSES AND HOME CARE, INC., NATIONAL ASSOCIATION FOR HOME CARE

Ms. CUSHMAN. Mr. Chairman and members of the committee, my name is Margaret Cushman. I am the executive vice president of Visiting Nurses and Home Care, Inc., serving the Greater Hartford and Greater Waterbury regions of Connecticut. In addition, I serve as secretary to the board of directors for the National Association for Home Care [NAHC] and chairman of its government affairs committee.

We commend you for holding these hearings.

NAHC is most concerned about the potential impact of the recommendations contained in the fiscal year 1987 administration's budget proposals, particularly as it relates to their impact on the Medicare beneficiaries. The President's budget proposal for fiscal year 1987 includes a recommendation that Medicare patients be charged an approximate $5 copayment for each home health visit up to 100 visits per year.

The copayment is based upon the in-patient hospital deductible and is estimated to save Medicare $100 million in 1987. The proposal is similar to one rejected by Congress last year.

This proposal would unfairly increase the burden on the Medicare beneficiaries. They currently are already required to make significant out-of-pocket payments for their home care and their other health care costs. Most recently in 1984, a copayment was imposed on beneficiaries equal to 20 percent of the cost of medical supplies delivered through home care agencies.

Most Medicare patients who are treated at home have fixed incomes of about $15,000 a year and below and find it currently difficult to meet their copayments on drugs, biologicals, and other sections of the health care copayments. Imposing a new copayment for home health visits would significantly increase the burden on the beneficiaries.

This is contradictory to the goal of discouraging excess utilization of institutional placement, while Congress has taken several specific actions toward achieving the goal of reducing unnecessary institutionalization.

Some patients will completely forgo home care because of the copayment, with the great possibility of complications occurring which would require expensive hospitalization which could be avoided. Beneficiaries may limit the amount of care they receive not according to their need but according to their financial status.

Creating obstacles to receiving home care without any correlation to medical necessity discriminates against the indigent and increases the need for more costly care. Far from saving millions of dollars, coinsurance would result in increased cost to Medicare. It would put home health agencies and fiscal intermediaries in the position of trying to collect the deductibles, and it would put them in a position of having to pay bad debt were it not possible to collect. It would also increase administrative burdens just sheerly based upon the expense of generating additional billings.

Those expenses would more than offset any savings to the program.

In addition, Congress repealed similar coinsurance provisions in the Medicare Act in 1980 for the express purpose of encouraging the utilization of home care. It was done in light of statistics showing the unmet need at that time.

While progress has been made, the need for home care has simply increased in the past 5 years and is much more acute than it was then.

It is important that we examine the copayment proposals in light of several other issues which are currently in front of us. Without question, there is a critical and growing need for the expansion of home care directly resulting from the implementation of the prospective payment system in hospitals.

Study after study is showing us that more and more patients are being discharged directly to home care from settings in hospitals that would have been unthinkable only 2 or 3 years ago. A study by the Southwest Long. Term Care Gerontology Center observed a 196-percent increase in the need for in-home skilled nursing care, and University of Virginia researchers reported a 27.5-percent increase in the intensity of care required at home since the implementation of DRG's.

We also need to consider the context of the Gramm-Hollings-Rudman cuts, which would impose a 1 percent cut on cost to home care. Home care still is one of the providers on a cost-based system. With a 1-percent reduction in cost, it would mean that regardless of how efficient providers are, they will still face a penalty from the implementation of that section as it is now proposed by the administration. The more efficient providers would receive greater penalties, while inefficiency would be encouraged. Applying the cut to the cost cap makes much more sense.

We also need to consider the impact in respect to waiver of liability. Final regulations published February 21 in the Federal Register would eliminate the waiver of liability presumption for all health care providers. The President's budget estimates $47 million would be saved in 1986 as a result of this regulatory initiative.

Congress instituted the current waiver presumption to protect Medicare patients whose care falls into areas of subjective judgment, as well as providers who need protection in order to render services falling into grey areas. With the changes in the diagnosis-related groups and the types of patients now being admitted to home care, the grey areas are increasing.

Many patients who previously might not have been looked at for coverage are now coming home. The questions in terms of coverage are increasing on a daily basis.

What these combined proposals would mean would be that providers and beneficiaries would be placed in a sort of Russian Roulette game in terms of who will provide care to fairly sick patients now going home. The waiver of liability, copayment and, indeed, the change in the cost limits from an aggregate basis and a ratcheting down of those cost limits would make a triple jeopardy for providers.

While we would like to think that the providers would not find it necessary to reduce access to care, in fact we can know that providers will be unable to carry the full burden of the cutbacks and that many beneficiaries will go without care.

We feel that it is terribly important to preserve a home care benefit, to make it available in the instances when it has proven to be cost-effective for the delivery of care.

Thank you.

[The prepared statement follows:].

Testimony of
MARGARET J. CUSHMAN, MSN, RN
Executive Vice President
Visiting Nurse And Home Care
Waterbury-Hartford, Connecticut

on behalf of the
National Association for Home Care

SUMMARY OF CONTENTS

1. The National Association for Home Care (NAHC) opposes the Administration's budget proposal requiring beneficiary co-payments for home health visits.

2. The hospital prospective payment system has resulted in patients being released more quickly in a sicker condition from hospitals, resulting in an increased demand and need for home care services.

3. NAHC opposes the 1 percent cuts to be imposed on HHAs pursuant to the Gramm-Rudman-Hollings Act. Home health agencies are cost-reimbursed and these cuts will be devastating to agencies.

4. NAHC urges that the waiver of liability presumption be retained for HHAs.

5. NAHC urges that legislation be passed, giving HHAs relief from the new cost limits effective July 1, 1985, allowing HHAs to aggregate costs.

6. NAHC urges that return on equity payments be retained for proprietary HHAs.

Mr. Chairman and Members of the Committee: My name is Margaret Cushman. I am the Executive Vice President of Visiting Nurse And Home Care, serving the Hartford-Waterbury region of Connecticut. I also serve as the Secretary of the Board of Directors for the National Association for Home Care (NAHC), and as the Chairman of NAHC's Government Affairs Committee. NAHC is the nation's largest Association representing home care professionals and paraprofessionals with approximately 3,000 member organizations. On behalf of these organizations, I would like to commend you for holding this important hearing.

NAHC is most concerned about the potential impact of the recommendations contained in the Administration's FY '87 budget proposals on Medicare beneficiaries. The President's budget proposal for FY 1987 includes a recommendation that Medicare patients be charged an approximate $5 copayment for each home health visit up to 100 a year. The copayment is based on one percent of the inpatient hospital deductible and is estimated to save Medicare $100 million in 1987. The proposal is similar to the one rejected by Congress last year. NAHC strongly opposes this proposal and urges Congress to reject it again for the following reasons:

(1) The proposal would unfairly increase the burden on Medicare beneficiaries. Medicare beneficiaries are already required to make significant out-of-pocket expenditures to finance their own health care. Just two years ago, a copayment requirement was placed on Medicare beneficiaries under the home health benefit by imposing a 20 percent copayment on all durable medical equipment purchased through Medicare Part A home health agencies (HHAs). Most Medicare patients treated at home have fixed incomes of about $15,000 and below, making it extremely difficult to pay for expensive drugs and biologicals that may be needed, as well as for charges in excess of Medicare for physician services, lab, x-ray, anesthesia, etc.. Imposing a new copayment for home health visits would significantly increase the financial burden on beneficiaries and would result in patients going without needed home care, or in unnecessary hospitalizations.

(2) This proposal is totally contradictory to the goal of discouraging excessive utilization of institutional placement. Congress has taken several specific actions toward achieving this goal in the past few years, and we would be penny-wise and pound-foolish to reverse this trend. Some patients will completely forego home health care because of the copayment, with the great possibility of complications occurring that require unnecessarily expensive hospital and physician care. Beneficiaries may limit the amount of care they receive not according to need, but according to financial status. Creating obstacles to receiving home care without any correlation to medical necessity discriminates against the indigent and increases the need for more costly institutional care.

(3) Far from saving millions of dollars, coinsurance would result in increased costs to Medicare because HHAs and/or the government would be put in the position of collecting coinsurance from the elderly. Medicare would have to cover the cost of non-paying beneficiaries by reimbursing agencies under their bad debt allowance. This will more than offset any savings which are anticipated from the implementation of coinsurance. Without question, an analysis of the added administrative cost and bad debt allowance resulting from the proposal is essential before a reasonable judgment can be made as to whether such a copayment requirement would actually save Medicare dollars or add, in the aggregate, to program costs.

(4) This proposal flies in the face of Congressional intent to expand the availability of home care services. Congress repealed a similar coinsurance provision in the Medicare Act in 1980 for the express purpose of encouraging utilization of home health care. This was done in light of statistics showing an enormous unmet need, and demonstrating that, because of the lack of home health alternatives, older Americans were being sent inappropriately to nursing homes at greater cost. While progress has been made, the need for home health care is even more acute today than it was 5 years ago.

At a time when the need and demand for home care is increasing, the Administration has, through a series of new regulations, guidelines and initiatives, been consistently chipping away at the home care benefit. The new copayment proposal constitutes one more effort to burden the provision of home care services to Medicare recipients.

It is important that this Committee examine the Administration's copayment proposal in the context of the following:

1. IMPACT OF DRGs

Without question, there is a critical and growing need for the expansion of home care services to be delivered to the American public. Not only are well known demographic trends vastly increasing these needs, the hospital DRG prospective payment system is also having a very considerable direct impact on the demand for more intensive home health services. There are numerous studies emerging that prove that DRGs are causing earlier discharges of patients who often have not been given sufficient time for their conditions to stabilize. These patients, therefore, have a greater need of higher acuity rehabilitative services. A study of data from the Health Care Financing Administration (HCFA), conducted by the Senate Special Committee on Aging reported a 37 percent increase in discharges from hospitals to home health agencies (HHAs) because of DRGs. A February 1985 report from the U.S. General Accounting Office found that discharges of hospital patients to HHAs had increased since DRGs in over 83 percent of the agencies surveyed. A study by the Southwest Long Term Care Gerontology Center observed a 196 percent increase in HHA skilled nursing services that had to be provided after DRGs. University of Virginia researchers reported on the 27.5 percent increase in the intensity of home care services needed by beneficiaries because of DRGs. Finally, in a survey recently conducted by NAHC of 2,100 Medicare-certified HHAs, 92 percent responded that DRGs had resulted in a sharp increase in the number of sicker patients requiring intensive medical or nursing care. There is no longer any question that DRGs are having a very significant effect on the need for home care.

2. GRAMM-RUDMAN-HOLLINGS CUTS

In order to enforce the Gramm-Rudman-Hollings Balanced Budget Act 1 percent Medicare benefit cutbacks, HCFA's intermediaries have been instructed to withhold 1 percent of claims and periodic interim payments (PIP) for HHAs beginning with bills showing services rendered on or after March 1, 1986 and until September 30, 1986 -- the balance of the federal fiscal year. These cutbacks will have a devastating effect on home health agencies. NAHC strongly opposes these cuts for the following reasons:

(a) It makes no sense to saddle _cost-based_ reimbursed HHAs already suffering under cost limits with the 1 percent reduction. This dollar cutback should have come from those parts of the Medicare program which are enjoying profits above their costs such as the DRG-based hospitals. The illogical result of the interpretation HCFA has made is to require every HHA and SNF to carry a 1 percent loss. HHAs are being cut on the basis of cost per visit, making impossible any alterations in service delivery to reduce costs.

(b) Even if the Congress considered it proper to reduce home care payments by 1 percent (or less) in the period March-October 1986, this reduction could only logically be made against the amount the program considered the defined "limit" of reasonable costs: that is, the cost cap. Obviously, agencies showing cost efficiency by being currently under caps, should not have a constant 1 percent penalty assessed against their already frugal organizations.

3. WAIVER OF LIABILITY

A final rule was published in the February 21 _Federal Register_ (page 6222) eliminating the Medicare waiver of liability presumption for HHAs and other providers, effective for services furnished on or after March 24. The President's budget estimates that $47 million will be saved in 1986 as a result of this regulatory/management initiative. NAHC strongly opposes this rule.

Under the waiver policy currently in effect, HHAs with a quarterly denial rate of 2.5 or less are paid for denied services if it is presumed that the HHA did not know or could not have reasonably known that the services were not reasonable and necessary, or constituted custodial care.

Congress instituted the current waiver presumption in 1972 to protect both Medicare patients whose care falls into an area of subjective judgment, and Medicare providers which need the protection in order to render services falling into the grey areas. The waiver presumption also serves to protect the beneficiary and the provider by providing a minimal "cushion" from what is also a subjective decision by an individual during the intermediary review process. Since providers may not bill the beneficiary once the claim has been submitted for coverage, the waiver provides an incentive for providers to submit claims even though they may not be absolutely sure it should be covered, but believe there is a reasonable likelihood it should and will be.

This proposal was advanced by the Administration for the last five years and rejected by the Congress. Its enactment would serve to further undermine both the public and provider confidence in the Medicare program. It would make accepting Medicare patients a kind of "Russian Roulette" at a time when more rather than less certainty and predictability is required. Given the vague application of constantly changing guidelines, directives, and regulations, it is difficult for home health agencies to be 97.5 percent perfect in their determination of eligibility. Removing this requirement would demand that they be 100 percent perfect in their determination, or suffer accordingly. The unreasonableness of such a requirement becomes even more apparent when one considers that a full 32.4 percent of FI claims denials get overturned upon reconsideration. NAHC believes Congress should restore the more realistic 5 percent rate of permissible error previously in law.

With home health agencies shifting to a system of ten new regional intermediaries, it is particularly important that the waiver presumption be preserved so that HHAs have some cushion for error as they adapt to the differing interpretations of the Medicare regulations and guidelines of their new FIs. NAHC supports the provision in the 1986 Budget Reconciliation Act which would retain the waiver presumption for HHAs for one year after the ten regional intermediary system is operational. The Congressional Budget Office has estimated that the provision is budget neutral. If reconciliation fails to pass within the next week, we urge support of H.R. 4065, introduced by House Aging Committee Chairman Edward Roybal (D-CA), and the companion bill S. 2122, introduced by the Senate Aging Committee Majority and Minority Chairmen John Heinz (R-PA) and John Glenn (D-OH), respectively. These bills mirror the provision in the Reconciliation bill.

It should be remembered that the group who will be hurt most by the elimination of the waiver are Medicare beneficiaries. The change will drastically reduce access to HHA Medicare services and will force these consumers to incur greater out-of-pocket costs in order to receive services that might have previously been covered by Medicare. This concern is evidenced by the coalition put together to retain the waiver, whose members included many provider and beneficiary groups, including the American Association of Retired Persons (AARP), the National Council of Senior Citizens (NCSC), and the National Council on Aging (NCOA).

4. COST LIMITS

In the past, home health agencies were reimbursed under the Medicare program for their reasonable costs, not exceeding the 75th percentile of aggregate agency costs. On July 5, 1985, HCFA published final rules effective July 1, 1985 which radically altered the way in which home health cost limits are calculated. Under the new rule, HHAs are reimbursed at 120% of the mean of visit costs and are not permitted to aggregate these costs.

Prior to July 1, 1985, HHAs were allowed to aggregate (average out) the costs from the various services which they were allowed to offer by Medicare. Thus agencies could balance out the costs of services, such as physical therapy, which were higher for them to provide against those that were more cost-effective. Under the new regulations, costs must be submitted per discipline, making it financially difficult or impossible for agencies to provide certain services. The inability of agencies to aggregate their costs will make it extremely difficult to meet the needs of beneficiaries. According to HCFA's own figures, using 120% of the mean, if HHAs are required to submit costs by discipline 70.2% would exceed the limits. If agencies were permitted to aggregate, still using the 120% figure, 37.8% would be over the limits.

If HHAs are not permitted to aggregate their costs under Medicare, severe disruption in the industry will result and beneficiaries will be unable to receive the services they so desperately need. Some of the many problems that will result include:

(a) Agencies will drop out of Medicare. Hundreds of agencies will go bankrupt.

(b) Agencies will no longer offer important but costly services, such as physical therapy for which they will not be adequately reimbursed.

(c) New agencies and small agencies will be hardest hit, regardless of how efficient they are. These agencies tend to have relatively higher costs and will be at an economic disadvantage. Older agencies will suffer to the extent they have tenured and, therefore, higher paid staff. The incentive will be to replace them with new staff members with lower salary demands. This will have serious consequences as far as the quality of home care services.

(d) Agencies in rural areas will be devastated. Such agencies have significantly higher costs for the delivery of services. Obviously, transportation expenses are much higher in these agencies, which must often send their employees great distances to care for clients who would otherwise go without health services altogether. In addition, therapists and social workers are often scarce and, therefore, more costly in rural areas. This increases the per visit length and cost. The policy of undermining rural home health agencies puts the Federal government in the incongruous position of spending millions of dollars in grants and loans to help create such agencies with one government program (the Public Health Service) and making it virtually impossible for them to serve clients through another program.

(e) Agencies which provide so-called "high-tech" care such as the care of ventilator-dependent persons, IV chemotherapy, or IV nutritional therapy will find it increasingly harder to do so. These services have relatively high costs and will be discouraged under the new reimbursement system. Ironically, these are among the very services which make it possible to move patients from hospitals into less intensive and much less costly settings.

(f) Agencies will be forced to be selective about which Medicare patients they take. Agencies may be reluctant to accept so called "heavy care" patients (such as stroke victims), whose cost per case is relatively high, and indigents.

(g) Agencies will lose management flexibility, important in making decisions such as the allocation of staff time. Government interference with internal management decision making constitutes an inappropriate intrusion in private enterprise, and is directly contrary to the management philosophy encouraged by prospective payment systems.

(h) The level of paperwork required by the new system will increase dramatically, leading to higher Medicare costs; ironically, such costs will have no relation to the provision of Medicare services.

Provider and consumer groups agree that the new cost limits are unreasonable and should be reconsidered. As the attached letter indicates, these organizations, including AARP and NCSC, are concerned that the limits "would significantly reduce the availability of these cost effective, socially desirable services to millions of Medicare beneficiaries."

We strongly urge that Congress pass legislation to permit HHAs to aggregate their costs.

5. RETURN ON EQUITY

On February 20, the Department of Health and Human Services published a proposed regulation in the Federal Register that would eliminate the return on net equity (ROE) that is now paid by Medicare to for-profit home health agencies. This so-called "ROE" provision was established at the beginning of the Medicare program in 1966 to put the investor who invests his own capital in a health facility in the same position as the operator who borrows the money.

Without such a payment, an investor would lose the return he could have received on his invested capital had he put it into a profit making venture rather than a program that only reimburses incurred costs. On the other hand, the operator who borrows would lose nothing: Medicare would reimburse him for the interest expense.

In January 1966, Mr. Robert J. Myers, the Chief Actuary of the Social Security Administration made much the same point in a statement to the Health Insurance Benefits Advisory Council, according to the Council's minutes.

Mr. Myers stated that:

> "while the report of the Committee on Ways and Means of the House of Representatives contains no specific mention of the payment of imputed interest to proprietary institutions, he had believed payment for the use of capital in the case of proprietary institutions to be an element of reasonable cost, and his estimates of the cost of the program included the cost of such payments. He explained that from the standpoint of cost to the program, it is irrelevant whether the proprietor is paid imputed interest for the use of his own capital or is reimbursed for the interest paid on borrowed capital; for purposes of preparing the cost estimates, it was assumed that the proprietor is unlikely to use his own capital if he is not paid for it."

Mr. Chairman, the Senate later in that same year, adopted an amendment calling on Medicare to pay proprietary nursing homes a return on net equity. The conferees indicated they intended the same treatment for proprietary hospitals. When participation in the Medicare program by proprietary home health agencies was first established at a later point in time, the ROE provision was extended to those providers as well.

The rationale for the return on equity is as compelling now as it was at the beginning of the Medicare program. In any case, it would be grossly unfair to withdraw the payments from home health agencies while continuing to pay it to other proprietary providers.

SUMMARY AND CONCLUSIONS

The ability of home health agencies to deliver the necessary services patients require upon discharge has been seriously eroded by the recent actions of the Administration. Imposing other restrictions on the Medicare home care benefit will exacerbate the problems in home health care service delivery. At a time of increasing concern about the expenditure of Federal money on health services, home health care is a humane and cost-effective alternative to institutionalization for elderly and disabled Americans.

Mr. Chairman, I appreciate having this opportunity to testify today and would be happy to answer any questions you might have.

December 10, 1985

The Honorable Dan Rostenkowski
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Rostenkowski:

We are writing to request your support for Section 715 of the Senate Budget Reconciliation Package which would impose a one-year moratorium on the implementation of a HCFA rule, published in the July 5, 1985 Federal Register, effective July 1, 1985, to impose new, more restrictive cost limits on home health agencies under the Medicare program. The Congressional Budget Office has indicated that the moratorium provision is budget neutral.

At a time when the demand for more intensive home health care is skyrocketing due to demographic trends and the impact of the hospital DRG prospective payment system, the HCFA rule would significantly reduce the availability of these cost effective, socially desirable services to millions of Medicare beneficiaries. HCFA predicts that over 70 percent of all home health agencies would suffer losses from these new limits, consequently hindering their ability to provide service.

Under the new rule, agencies could no longer aggregate costs. This deprives them of the flexibility needed to balance out the costs of services such as physical therapy, which are more costly to provide, against those which are less expensive. Without question, this rule makes it extremely difficult or impossible for home health agencies to provide the nation's elderly with some of the high technology or higher cost services. Beneficiaries with multiple problems and those living in rural areas will have particular difficulty receiving care. Furthermore, the payment change is directly contrary to current efforts towards development of an equitable prospective reimbursement system for home health agencies under Medicare. We also agree with the assessment by Senator Dave Durenberger, Chairman of the Senate Finance Subcommittee on Health. In his letter to former HHS Secretary Margaret Heckler, Senator Durenberger expressed his concern over "the setting of budgetary policy through regulation" and noted that the HCFA proposal "crosses this fine line between policy implementation and policy making".

We appreciate your help in this matter and hope you will support the cost limit moratorium provision so that appropriate studies can be undertaken to ensure that any methodological change will not adversely affect Medicare beneficiaries.

Val J Halamandaris

Val J. Halamandaris
National Association for Home Care

Sana F. Shtasel
American Association of Retired Persons

Janet A. Myder

Janet A. Myder
National Council of Senior Citizens

William Hermelin
American Health Care Association

Gloria S. Hope, R.N., Ph.D.
American Nurses' Association

Edward F. Howard
Villers Advocacy Associates

Dean M. Sagar

Dean M. Sagar
American Association of Homes for
the Aging

Jack M. Owen
American Hospital Association

William J. Cox
The Catholic Health
Association

STATEMENT OF ALAN P. SPIELMAN, EXECUTIVE DIRECTOR OF GOVERNMENT RELATIONS, BLUE CROSS & BLUE SHIELD ASSOCIATION

Mr. Spielman. Mr. Chairman and members of the subcommittee, the Blue Cross and Blue Shield Association appreciates this opportunity to comment on the administration's fiscal year 1987 Medicare proposals. My written statement contains our view on the administration's proposals relating to beneficiary cost-sharing, physician and hospital reimbursement, including the capital proposal, the voucher concept, and the Medicare contractor budget, and I would ask that the entire statement be included for the record.

Mr. Pickle. That will be done for you, Mr. Spielman, and for all the gentlemen who testified.

Mr. Spielman. Thank you, Mr. Chairman.

This afternoon, I would like to focus on the important Medicare administrative functions performed by intermediary and carrier contractors and how the current and proposed funding levels for these functions will create major problems for beneficiaries, providers, and the Medicare program. Intermediaries and carriers process claims, make coverage and payment determinations, communicate with providers and beneficiaries, and implement complex program changes. As the subcommittee well knows, this administrative structure did perform a monumental task in implementing the prospective payment system under short deadlines and while numerous other changes were being made to the program.

The ability to implement program changes promptly and accurately and to cope with the ever-growing claims volume and complexity of the program is of critical importance to this subcommittee, and we commend you for your past efforts in this area. For example, you recommended providing funding to implement the physician payment changes and additional funding for cost-effective audits and claims review functions.

This year, however, we face a serious funding shortfall, and we believe that the administration's funding request for fiscal year 1987 is inadequate to meet the needs of the program. Despite the fact that Medicare contractor funding more than pays for itself in terms of benefit dollars saved, this funding is not exempt from the automatic cuts under the Gramm-Rudman-Hollings legislation.

Moreover, it is not covered by the special rule limiting Medicare program cuts to 1 percent for fiscal year 1986 and 2 percent in later years. As a result, the fiscal year 1986 automatic cuts reduced Medicare contractor funding by 4.3 percent or about $41 million, and the Health Care Financing Administration expects intermediaries and carriers to cope with this funding shortfall by delaying claims payments to beneficiaries and providers.

Slower claims payments will create cash-flow problems that could be particularly serious for low-income beneficiaries, and for providers experiencing other financial problems.

The contractor funding situation also is expected to result in a deterioration in our ability to respond to beneficiary and provider inquiries. In addition, the fiscal year 1986 funding level for provider audit activities, which save the program millions of dollars, was recently reduced.

For fiscal 1987, the administration has recommended a basic funding level of $957 million for Medicare contractors. This amount is about $6 million less than Congress considered necessary for this current year in the appropriations bill. While we have not yet completed a thorough evaluation of this recommendation, our initial assessment is that a 9- to 10-percent increase in expected claims workloads, coupled with a 3- to 4-percent increase in inflation, cannot be adequately accommodated within the request. The restricted funding level also will result in inappropriate Medicare benefit payments as contractor claims review and other capacities are reduced.

We will be sharing our concerns about the Medicare contractor budget with the Appropriations Committee, which has jurisdiction over this aspect of the budget; however, we would like to work closely with this committee in evaluating the effects of any new program changes on Medicare administration.

Also, we would urge you to review carefully the forthcoming GAO report on Medicare administration, which was required by the Deficit Reduction Act of 1984.

Your support once again in reinforcing the policy that severe restrictions in the resources devoted to Medicare Program administration are pennywise and pound foolish will help assure that the program works as intended by the Congress.

Thank you, Mr. Chairman.

Mr. PICKLE. We thank you, Mr. Spielman, and thank all of you people who have testified today.

Your entire statement will be included in the record.

[The prepared statement follows:]

TESTIMONY
OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and members of the Subcommittee, I am Alan P. Spielman, Executive Director of Government Relations for the Blue Cross and Blue Shield Association, the national coordinating agency for all Blue Cross and Blue Shield Plans.

Thank you for this opportunity to comment on the Medicare proposals contained in the Administration's Fiscal 1987 budget. Our perspective is based on our experience both as Medicare intermediaries and carriers, and as the nation's largest provider of health care protection covering nearly 80 million Americans. Our comments today will address several of the major Medicare program changes proposed in the Administration's budget as well as our concerns about the administrative structure of this important program, given the level of funding recommended by the Administration for FY 1987.

In particular, we ask that you consider the following points as you review the Administration's Medicare proposals:

- If Congress determines that beneficiaries should bear a greater share of Medicare costs, increases in premiums are preferable to increases in deductibles or copayments. However, if a significant increase in the premium is considered, we would urge exploration of mechanisms to provide relief from this new financial burden for low-income beneficiaries.

- The proposal to reduce physician payments for specific overpriced procedures deserves support. However, Medicare carriers may need some additional funding to implement this proposal. We also support the elimination of the freeze on Medicare payments to physicians and on the fees charged by non-participating physicians.

- The projected annual update of 2 percent in hospital prospective payment rates will create financial problems for some hospitals in view of inflation, the 1986 rate freeze, the potential Gramm-Rudman-Hollings cut for FY 1987, and the continued lack of payment refinements. Payment adjustments for severity of illness and other factors should be considered.

- While we support the concept of a capital add-on factor for PPS rates, we urge that thorough consideration be given in the legislative process to the effects of various proposals on hospitals in different circumstances. For instance, we question whether the payment formula and transition period under the Administration's proposal would be adequate.

- The proposed voucher legislation is conceptually appealing and Congress should support experimentation with areawide carrier capitation as another cost-effective approach to the financing and delivery of Medicare services.

- A stable administrative structure is critical to the control of benefit payments, the timely and accurate handling of claims, prompt response to beneficiary and provider inquiries, and the smooth implementation of complex program changes. However, the proposed budget would under-fund this important function, thus creating major problems for beneficiaries, providers, and the Medicare program.

We would now like to address these points in greater detail.

Proposals Affecting Program Administration

As you review proposals to change the Medicare program, we urge you to consider their administrative implications. We commend the Subcommittee for its past recognition of the need for adequate funding to support effective program administration. Last year, the Subcommittee recommended funding to implement major program changes, and the pending FY 1986 reconciliation bill would require that additional funds be made available for enhanced, cost-effective audits and claims review functions. These actions save substantial program dollars and help assure that the program works smoothly for beneficiaries and providers.

Unfortunately, the proposed fiscal year 1987 funding level for Medicare intermediary and carrier contractor activities would be seriously inadequate for current program needs, much less the implementation of any program changes. In addition, under the Gramm-Rudman-Hollings legislation, Medicare administrative funding is not covered by the special rule limiting Medicare program cuts to 1 percent in FY 1986 and 2 percent in later years. As a result, the FY 1986 sequestration reduced administrative funding by 4.3 percent, or $41 million, and the Health Care Financing Administration expects intermediaries and carriers to delay claims payments to beneficiaries and providers to cope with this funding shortfall. Slower claims payment will create cash-flow problems that could be particularly serious for low-income beneficiaries and for providers experiencing other financial problems. The contractor funding situation also is expected to result in a deterioration of the ability of contractors to respond to beneficiary and provider inquiries. In addition, FY 1986 funding for audit activities has been recently reduced by $10 million.

For fiscal year 1987, the Administration has recommended a basic funding level of $957 million for Medicare contractors. This amount is $6 million less than Congress considered necessary when it enacted the FY 1986 Labor/HHS Appropriations bill. While we have not yet completed a thorough evaluation of the Administration's proposed FY 1987 Medicare contractor budget, our initial assessment is that a nine to ten percent increase in expected claims workloads coupled with a three to four percent increase in inflation cannot be adequately accommodated within the Administration's budget request. The restricted funding level will also risk additional Medicare benefit payments.

We will be sharing our concerns about the Medicare contractor budget with the Appropriations Committee, which has jurisdiction over this aspect of the Medicare program. However, we would like to work closely with this Subcommittee in evaluating the effects of any new program changes on Medicare administration. In addition, we would urge this Subcommittee to review carefully the findings and recommendations of the General Accounting Office regarding Medicare program administration when the GAO submits its report on this subject as required by the Deficit Reduction Act of 1984. Your support once again in reinforcing the policy that severe restrictions in the resources devoted to Medicare program administration are "penny-wise and pound-foolish" will help assure that the program works as intended by the Congress.

Proposals Affecting Beneficiaries

Among the Administration's proposals affecting beneficiaries are proposals to increase the Part B premium, increase and index the Part B deductible, and introduce a copayment for home health services.

If Congress decides that some sort of increase in beneficiary cost sharing is necessary to help reduce the deficit, we believe that the most equitable approach would be through

Part B premium adjustments. Premium adjustments spread the cost burden among all beneficiaries, rather than targeting only beneficiaries who have need of services. The proposed increase in the Part B deductible would hit beneficiaries when they are ill and can least afford out-of-pocket costs. Beneficiaries now share significantly in the costs of Part B services - through the premium, the deductible, and the coinsurance - and some beneficiaries cannot afford even this level of cost-sharing. If Congress considers a substantial increase in the Part B premium, we would recommend that you also consider mechanisms to provide some relief for those lower-income beneficiaries who are not eligible for Medicaid.

Physician Reimbursement Proposals

We believe that the proposal to reduce physician payments for specific overpriced procedures deserves support. For instance, a recent report by the Congressional Office of Technology Assessment concluded that payment levels are maintained for many new medical technologies even when resource costs decline over time as the new technologies become more widely available.

The Administration does not propose to continue the freeze on Medicare payments to physicians and on the charges of "non-participating" physicians who do not always accept assignment. We believe that the proposal to reduce payments for specific overpriced procedures is preferable to an arbitrary freeze on all Medicare physician payments. While we support repeal of the current freeze on non-participating physicians' charges we would urge you to consider continuing some form of financial incentive for physicians to participate in Medicare. Encouraging greater physician participation under Medicare will help to protect beneficiaries from liability for increased charges that will occur when the freeze is lifted.

Hospital Reimbursement Proposals

The Administration's budget assumes that hospital PPS rates would be raised by 2 percent. At this point, it is too early to determine whether the projected 2 percent increase in PPS rates adequately takes into account amounts "necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality," as required by current law. However, if the mandatory cuts required by the Gramm-Rudman-Hollings legislation go into effect for FY 1987, this increase would be wiped out entirely. The prospect for a freeze in PPS rates or a moderate 2 percent increase highlights the importance of introducing refinements to the payment system, such as a severity of illness measure as soon as possible. Such refinements are necessary to provide assurance that the "winners" and "losers" under the constrained system result from differences in operating efficiency and are not simply the result of inadequacies of the system. If these improvements are not technically feasible by October 1, 1986, their prompt development and implementation should be given the highest priority.

The Administration also proposes to reform payment for capital costs of PPS hospitals. Under the proposal, a set amount for capital would be added on to PPS rates. According to recent testimony before the Subcommittee, the amount for capital would be a blend between the national average amount per DRG and a hospital-based component based on historical, updated costs. Over a four-year transition period, the capital add-on increasingly would be based more on the national average and less on the hospital specific factor.

We support the concept of a capital add-on. Capital-inclusive DRG pricing offers several advantages over the current capital cost pass through. It would be consistent with the price-based payment method created under PPS, eliminate the artificial separation of capital and operating costs and create incentives for hospitals to minimize capital expenses and defer projects when the cost of capital is high. Therefore, we agree in principle with the development of capital-inclusive DRG pricing.

However, we question whether the Administration's proposed payment method will, in practice, fairly compensate health care institutions' capital costs. Critical in this regard are the formula used to calculate the capital factor and the length of time and manner of transition for implementation of the new capital payment method. The proposal could jeopardize many hospitals' financial security by placing too little emphasis on hospital-specific costs during the transition and by providing too little time to allow hospitals to adjust to the new payment system.

For example, the hospital-based payments would not be truly hospital-specific since the Administration plans to use a fixed base of FY 1983 capital payments to determine each facility's hospital-based payment. Also, the hospital-based portion of the capital payment would be reduced each year by an accelerated phase-out of payments for return on equity and interest earned on funded depreciation. In addition, the national portion of the capital payment would exclude return on equity payments to proprietary hospitals and interest earned on funded depreciation to voluntary hospitals. While we agree that payment for return on equity and interest offset need not be continued under the prospective payment system, we question whether payments for these factors should be reduced as abruptly as the Administration proposes.

We caution against viewing payment to hospitals for capital primarily as an opportunity for deficit reduction. Medicare payments for capital influence hospitals' investment decisions, and in some instances, their ability to obtain financing for such investments.

Therefore, any changes in Medicare's payment policies for hospitals' capital expenditures carry far-reaching implications for the cost and availability of health care services in the United States.

As a cautionary measure, we believe a mechanism should be established which enables adjustments to capital payments where it is clearly demonstrated to be necessary for the continued viability of needed facilities.

Finally, we must note our concern with revising payment for capital through the regulatory process. In our opinion, the method of Medicare payment for capital cost is of much significance to the future organization and configuration of the health delivery system. We, therefore, believe payment for capital should be the subject of broad public debate and would be more appropriately considered as part of the legislative process.

Vouchers

The President's budget also recommends enactment of a voluntary voucher program to enable beneficiaries to buy private coverage at least equivalent to Medicare benefits from qualified organizations under contracts with the government. This would represent an expansion of the Health Maintenance Organization and Competitive Medical Plan option enacted in 1982.

We believe the best promise of overall Medicare savings is through providing managed care and introducing market-based efficiency incentives, while enforcing adequate beneficiary safeguards. The voucher may be one approach in this direction. We are also encouraged by the approach of capitating fiscal intermediaries and carriers for the financing of Medicare services in a defined geographic area, which is now being discussed within the Administration.

The Administration's voucher proposal, S. 1985, incorporates several improvements over the current authority. For example, Medicare capitation would be available not only to entities that provide services, but also to entities such as insurers and preferred provider organizations that arrange for and finance services. In addition, flexibility is provided on use of capitation payment amounts that exceed expected expenses, thus providing increased incentives for efficiency.

However, we are concerned about several specific aspects of the legislation. For instance, the legislation may not provide adequate safeguards for beneficiaries, and it will be very difficult to determine whether health benefit organization coverage is actuarially equivalent to the traditional Medicare benefit package. We are also concerned that capitation payments may not accurately reflect the risk associated with the organization's enrollment mix and with the possibility that the voucher's purchasing power might be maintained at an adequate level only for the healthiest beneficiaries.

When legislation on the voucher is introduced in the House of Representatives, we would like to provide the Subcommittee with detailed comments on the legislation.

Summary

In closing, we are pleased to be provided the opportunity to offer comments on the effect of the budget's proposed Medicare changes. We have emphasized the importance of a stable administrative structure for the Medicare program and have suggested specific issues to be addressed in your review of the Administration's FY 1987 budget proposals. We will be pleased to work with you as you begin addressing these very difficult issues.

Mr. **Pickle**. Let me ask two or three questions.

Dr. Newmann, you stated that renal patients find the ESRD networks to be very helpful in several ways, and you listed in your testimony four or five reasons why they are very helpful. Yet the administration has been trying to eliminate these so-called networks or this approach.

Why do you think the administration is so opposed to the network?

Mr. **Newmann**. I have seen it basically as a cost-cutting measure. As I stated in my testimony, one of the most valuable things the ESRD networks is provide patients with a means to deal with grievances when they have complaints about their care, if they cannot resolve these in their dialysis units. This has been very effective in a number of places.

Second, the networks have collected the only outcome data as to what's happening to these kidney patients. HCFA has collected cost data through Medicare intermediary claims.

As I recommended, we feel that this committee should require HCFA to monitor the death and the hospitalization data over time to see if the 1983 reimbursement reductions cost changes have had an effect on what's actually happening to these patients. As you know, our lives depend on these treatments thrice weekly.

So I cannot see any rationale other than the cost-reduction effort without regard for quality of care to dismantle these networks.

Mr. **Pickle**. Cost may be the primary factor why they oppose it or at least looking for some other route. You say the better thing to do is to get more funding to the individual. And how do we do it?

Mr. **Newmann**. I'm sorry?

Mr. **Pickle**. Did you say the best way to do would be to get more funding from the individual? Did I understand you?

Mr. **Newmann**. No, no. I haven't made that statement.

Mr. **Pickle**. Well, what would be a better way, then, to solve this problem?

Mr. **Newmann**. Well, if you're talking about saving money in terms of the ESRD Program, I have testified before this committee in earlier years, suggesting that serious concern be given toward rehabilitation of ESRD patients. As it is now, the whole Social Security system of disability income has many disincentives for going back to work, and my suggestions over the years have been to get serious about rehabilitation, so that patients capable of working, return to work, become taxpayers, and will therefore not only add to the Government's income, but——

Mr. **Pickle**. Then you would recommend that the networks do rehabilitation work?

Mr. **Newmann**. Yes, and many of them have held workshops and assisted patients in doing that. The network in Maryland, just last year with our patient association's help, enabled an individual to retain his job, where he was being discriminated against based on his illness, but he was perfectly capable of holding down that job, and he now has it.

Mr. **Pickle**. All right. Well, I thank you.

Now, Dr. Berger, in your testimony you stated that the rate of return on investment capital for dialysis facilities was just barely enough to sustain present investment levels. Yet I understand that the rate of reduction from 1983 to 1985, during this time that they had this great reduction, they had 177 facilities that have opened, and 80 percent of these facilities are for nonprofit.

Now why are there so many new facilities opening, if they're just barely enough to sustain survivability?

Dr. **Berger**. I guess my answer to that has two parts. The first is that the number, 177, may well be misleading in that many of the facilities—the figures that HCFA provides on facility openings are—do not reflect facilities which open, become totally equipped, and which begin to treat chronic dialysis patients. They are facility approvals.

There are any number of reasons why some facilities get approved, but never begin to see chronic maintenance dialysis patients. I don't know what the real number of facilities, which have actually, since 1983, opened and begun to see patients, is, but it is smaller than the 177.

However, when we look at the rate of growth of the facility network, either measured in terms of the number of chronic dialysis facilities or a measure which is, in fact, more sensitive to the capacity requirements, which is the number of treatment stations in the system, OK, those growth rates, which historically were approximately equal to the rate of growth of the beneficiary population, have since 1981, when the first rumors of the 1983 rate reduction came into effect, lagged substantially behind the rate of growth in the patient population.

Some facilities did open last year. Some will open this year. Some will open next. But not enough facilities to provide all of the additional treatment capacity that's required for the 8 to 10 percent of additional patients who join the chronic hemodialysis population each year.

Mr. **Pickle**. All right. Mr. Daub, do you have any questions of the panel?

Mr. **Daub**. A few. Thank you, Mr. Chairman.

Let's stay with our first two good witnesses with respect to their subject, comment on what technology has done in this field, and what you expect technology to do in the next 5 years.

I understand that there's a new seal that now can be implanted permanently to avoid infection and a portable machine about ready to be approved. It can be strapped on and worn, and will avoid a lot of these three-visits-a-week thing, and evidently may improve availability, reliability, and reduce costs. Yes or no?

What do you think will happen in the next 5 years on this subject in terms of technology?

Mr. **Newmann**. Much of the technological advance which has resulted in reduced cost has to do with the cost of the actual artificial kidney, the dialyzer. When I began dialysis in 1971, these were costing $20 to $25 apiece. Now you can buy them anywhere from $10 to $13 or $14. I'm not sure there are additional efficiencies in that particular area.

The machine you refer to, if I know the one you're talking about, is not one that you can strap on and have your entire treatment taken care of. It's a machine that you can use for about 40 minutes, and then you have to go hook up to the water and the dialysate source, and you would do that intermittently over your 4- to 5-

hour treatment. I don't know whether that's a cost-saving measure or not.

Actually, technology has improved very rapidly in the last few years in terms of increasing the quality of the treatments. There are a few artificial kidney membranes which are more biocompatible than the most commonly used membrane cuprophane. The more biocompatible membranes cost more than the $10 to $13 to which I referred. However, it's been shown that there are fewer morbid events during and between dialysis when these improved membranes are used. The solution, bicarbonate instead of acetate, is believed by many to provide a much smoother dialysis treatment causing fewer headaches, and cramps, for example. It is a bit more expensive than the more commonly used acetate. Bicarbonate happens to be the body's natural buffer. Patients seem to feel better when they use it.

And finally there are a few dialysis machines which exactly ultrafilter the excess liquids that dialysis patients take in. Previously dialysis machines only estimated liquid removal; and dialysis patients were very nervous, as were staff, as to whether they would finish the treatment above the appropriate weight with too much liquid on, so that they'd have to strongly restrict their diet in between treatments, or too low, in which case they would get cramps and low blood pressure. These new machines are more expensive, but are much more dependable in removing the desired amount of fluid.

So if I were recommending high quality of care, I would recommend current state-of-the-art, equipment and supplies, which are more expensive, OMB's efforts to reduce the current rate would make state-of-the-art dialysis very difficult to afford. And I might say that that state-of-the-art dialysis probably, if followed over time, would result in far less hospitalization and perhaps even less mortality.

So the technology has been increasing at an impressive rate; however, reimbursement at this point may very well sacrifice some of the quality of care which this technology currently is promising.

Mr. DAUB. So the Government ought to pay for it all?

Mr. NEWMANN. No; I think the current situation where the Government is paying 80 percent and then coinsurance takes up the remaining 20 is appropriate.

And again, I remind you, the actual cost pertreatment perpatient has gone down since 1973. The fact that we're keeping alive 10 times as many patients in 1980 as we were in 1973 accounts for the vast majority of the increase in costs. It's a terribly successful program.

Mr. DAUB. You know the history of all of this. Of course, we're all delighted with our progress. It was some years ago during the first day of the hearings out in—where was it, Oregon or Washington—and the question was in front of 10 people, 1 with a hood—which one are you going to save and which 9 are you going to deny the care to, which ones will you kill. And we've come a long way, haven't we, since those days?

Mr. NEWMANN. Absolutely.

Mr. DAUB. What about the networks? Was that $5 million we are spending on them? The President's budget calls for their elimination. Do you suppose it is because of the GAO study a couple of years ago that said that regional offices handle the functions? It seem to me we have pinched their budgets so much that this may not now be the case. In any event, Congress has decided to ignore that old recommendation and continue to fund them.

Mr. NEWMANN. Yes. I fully support the decision to continue funding the ESRD networks. However biased I may be as a patient, as well as a past-president of the patient group which represents these thousands of patients, the networks have been very helpful, some not as successful as others. However, annually, their services and the reliability of their data have improved, so that we're reaching a point now where we can really begin to tell what's happening to patients.

Mr. DAUB. Thank you very much.

Let me ask Ms. Cushman about premature discharge—do you think that that means that we made a mistake with DRG's?

Ms. CUSHMAN. Interesting question. I do not know that I would use the phrase premature discharge because that implies that people are getting out who should not get out.

Mr. DAUB. Sicker and quicker?

Ms. CUSHMAN. Certainly sicker and quicker.

Mr. DAUB. So did we make a mistake then, with DRG's?

Ms. CUSHMAN. I do not believe that the mistake has been made with DRG's as much as that the law and the way it has been written does not recognize how to treat these patients when they are not in an institution.

In fact, in the regulations, the final notice by HCFA that would do away with waiver, it makes a note in there that the Medicare Home Health Benefit was only meant to be—only intended as a last stop in the continuum of care. What home care now can be and do cost effectively is to be a stop immediately after ICU. We are seeing an increasing number of patients who once would have gone first to a floor in a general hospital from the intensive care unit and then to a step-down unit and then be discharged, now being discharged directly from the intensive care unit to home.

However, the home care benefit is not covering the more intensive needs of those patients. So we have not picked up on the other side.

To the extent that that is not taking place, and that the definitions of coverage are grey, it is a serious mistake for patients.

Mr. DAUB. So what we need to do then is perhaps consider DRG somewhat successful and look at that intermediate care and the cost, whether it is home health or another step down from that intensive care discharge.

But it is not a premature discharge, but rather we are making some decisions that maybe just are not allowing another setting to take over in an appropriate way. And I suppose, for the Government to pay for it.

Ms. CUSHMAN. That is correct.

Mr. DAUB. My last question, to Mr. Spielman, I read your testimony, skipped over a part that you mentioned there. Is Blue Cross and Blue Shield in favor of the voucher recommendation of the administration?

Mr. SPIELMAN. Conceptually, we think it has promise. As I pointed out in our full statement, there are a number of problems and issues relating to the specific legislative proposal. And we would like to prepare some highly detailed comments on it.

Granting additional flexibility on the types of organizations that can receive capitation payments, and some additional flexibility on how some of those capitation payments will be used for the long-term benefit of the Medicare patients is worthwhile.

But there is a whole host of issues relating not only to how you administer it, but also to how you compare the equivalents of various plans and whether or not beneficiaries are adequately protected.

We would like to work with this subcommittee on a lot of the details relating to this proposal.

Mr. DAUB. Thank you very much, Mr. Chairman.

Mr. PICKLE. Well, Mr. Spielman, what is your organization's position with respect to the DRG? Do you think the DRG Program has been successful or not?

Mr. SPIELMAN. Yes; I think it has been successful, in large part. However, one of the points that I pointed out in my testimony is that the administrative structure of the program is highly strained. So this has been a major change that has come along in Medicare when other changes have also been happening simultaneously.

And a lot of providers are not getting paid quite as promptly as they used to.

But I think, by and large, the notion of moving to prospective payment is a step in the right direction. We certainly do it in our private business.

And similarly, as my statement points out, conceptually we think capital can move to a prospective payment system over the long term.

Mr. PICKLE. One last question. I wanted to ask Margaret Cushman, under the Gramm-Rudman-Hollings proposal payments to all providers are reduced 1 percent in 1986 and 2 percent in 1987, and you protest that with respect to home health care.

Why should you be set aside, separate and apart from other providers, in limitations or reductions?

Ms. CUSHMAN. My protest in testimony is related to the concept of how the 1 percent is applied to cost versus charge. Because of prospective payment, hospitals have a margin for changing their operation and, therefore, achieving efficiency and enduring the cut, or being able to accomplish cost. Because it is going to be applied directly to cost, no matter what you do to your cost, no matter how much better you get, you still have to have the provider receive 1 percent less than that cost.

That is a very difficult concept to deal with.

Mr. PICKLE. Well, I have always had the feeling that generally speaking the DRG is working well. And whether they get out a little bit too soon or not, but they do get them out of the hospital quicker, or at least on time.

But when they go over to the home health care, you are not limited in your charges, because you can get all the other kind of equipment, and a whole lot of other facilities that the hospitals are limited. You have an open field, so to speak, to add all these things and not have to be accountable for it.

Now I do not know whether—you would probably disagree with that, but I hear that is one of the complaints from the medical profession.

And yet, even with that right, if you have got it, you still protest the limitation for the other facilities. Now how do you justify that?

Ms. CUSHMAN. I would respond in two ways. One, the argument suggests that the primary cost components in home care are discretionary. In fact, over 85 percent of the total cost of most agencies—or for that matter, any agencies I personally know—are direct labor expenses, the direct cost of providing the care through the individual who is providing it.

The add-on cost, in terms of any equipment or supplies are not reimbursed, except as they are directed related to the care of that patient, because the additional supplies and equipment are covered under durable medical equipment reimbursement.

The other problem with the argument is that no matter what a home care agency would do, the 1 percent would apply. If we were talking about 1 percent against a charge or some reasonable fee or prospective payment, that is more easy for me to conceptualize. But it is a penalty.

No matter what cost efficiencies are achieved by an organization, that organization will still take an additional 1 percent cut.

Mr. PICKLE. I have the feeling we are going to be hearing further testimony in consideration on the overall cost of operation of the home care facilities, just by the very nature of their establishment.

That completes the testimony for this panel.

The House now has a vote and we must go to the floor.

I thank you for your testimony and for your response to our questions. We may be submitting additional questions that we would like you to respond to us in writing as quick as you can.

There being no other questions, the committee will stand adjourned.

[Whereupon, at 1:55 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE
AMERICAN ACADEMY OF FAMILY PHYSICIANS

In the following statement the American Academy of Family Physicians focuses on those proposals in the Administration's FY87 budget which specifically would affect physician reimbursement and Medicare support of graduate medical education. Put simply, the policy implications of the changes proposed in the President's budget are significant, and would exacerbate an already negative environment for the provision of primary care services. The reasons for this are complex and present a difficult set of choices for Congress at a time when federal financial resources are stretched to the limit.

The Fifth Report to the President and Congress on the (Status of Health Personnel in the United States) (March 1986) notes a "continuing decline in the percentage of general/family practitioners (as a proportion of all physicians)." It further states "About 14 million persons or 6 percent of the U.S. resident population remain underserved in the nation's primary care health manpower shortage areas." Family practice residency graduates do practice in underserved areas--both inner city and rural areas. Family physicians are trained to care for patients of all ages--including the elderly. Family physicians currently provide care to a significant segment of the Medicare population, and will continue to do so at an increasing rate, as the age of their patients increases. The Administration's proposed Medicare cuts are totally inconsistent with the obvious health care needs of the country for cost-effective, preventive, ambulatory--based, primary care services.

Of great concern to the Academy is the Administration's budget proposal to eliminate, by regulation, Medicare's share of reimbursement for the education expenses of residents. While the proposed budget does not detail how this would be accomplished, officials of the Health Care Financing Administration have verbally explained that Medicare intends only to pay for its proportional share of residents and interns salaries and fringe benefits.

To explain the potential implications of this proposal, the Academy would like to share with you some data which discusses the elements involved in family practice residency training programs, and provide some insight into the magnitude of the proposed funding reductions. For this purpose we have examined conclusions of a study conducted by the University of Oklahoma.

The publication "A National Study of Financing of Family Practice Residency Training Programs" examines data on the costs of family practice residency programs and concludes that the mean cost per family practice resident is $79,429. In this study, program costs per resident are divided into four categories: Faculty costs, resident costs, family practice center costs and education administration costs. The following describes the components of each of the four cost categories and notes the percentage of total program costs as determined by this study.

Faculty costs: Faculty costs include faculty salaries and fringe benefits, travel, supplies, contract services such as visiting professors, and miscellaneous items such as liability insurance, licenses, memberships, recruiting and moving expenses. The mean faculty cost per resident was $22,955, which is 27.33% of total costs per resident.

Resident costs: Resident costs include salaries and fringe benefits, travel, supplies, contract services such as telephones and pagers, and miscellaneous costs including insurance, licenses, memberships and recruiting. The mean resident cost per family practice resident was $27,918, which comprises 32.11% of total costs.

Family Practice Center Costs: Costs incurred by the Family Practice Center for resident training include clinic personnel salaries and fringe benefits, travel, all medical and clinical supplies including laboratory and x-ray supplies, medication, drugs and vaccines, office supplies, cleaning, laundry, educational supplies for patient education, contract services such as lease, phones and equipment rental, clinic equipment and other costs such as insurance. Family practice center costs comprised 34.14% of total program costs, with a mean of $27,219.

Education Administration Costs: Education administration costs include administrative salaries and fringe benefits, travel, supplies and equipment, and other costs such as leases, telephone, and printing. These mean costs per resident were $7,048 or 6.62% of total costs.

Each of the four cost categories described above is integral to the education of family practice residents. While the data cited is from a sampling of the mean costs of approximately 150 programs, it serves to illustrate that the educational costs of family practice residency programs include substantially more than simply residents salaries and provides the approximate percentage of total costs of the four categories.

Yet the Administration proposes to have Medicare pay only for its proportional share of residents salaries, which in the study comprises only 32% of total program costs per resident. This would result in Medicare ceasing to pay its share of approximately 68% of the educational costs of training family practice residents.

Since its enactment, the implementation of the Medicare law has responded to the Congressional intent that Medicare pay its proportional share of the education of interns and residents. The Administration now intends to relieve the Medicare program of its responsibilities in this area. The Academy believes that the federal government has a societal as well as a statutory responsibility to continue to finance proportionally the training of interns and residents through the Medicare program.

For the financially fragile family practice residency programs, the significant decrease in Medicare support which would result from this decision would be devastating to the future of the programs. Attachment A tracks the development of accredited family practice residency programs from 1969, when family practice became a nationally recognized medical specialty, through July 1985. After reaching a peak in 1983, the number of accredited family practice residency programs has declined in the past two years. Additional financial constraints, such as that proposed by the Administration, inevitably will result in more program closures and a reduction in the training of family physicians. The problem for family practice training programs is inter-related with and exacerbated by Medicare physician payment policies. Because of significant payment differentials between physicians of different specialties providing similar services, and between rural and urban areas, the existing reimbursement system discourages the type of care it should be encouraging--preventive, comprehensive, ambulatory-based care--while rewarding procedurally-oriented, inpatient, episodic care. Family practice training programs therefore have difficulty generating revenues from patient care because many of the services provided by family physicians are not reimbursed by Medicare, or are reimbursed at a low level relative to other services.

Our comments on the Administration's proposed efforts to further restrain Medicare physician payment therefore relate to the impact on practicing family physicians and on family practice residency training programs.

A modification in Medicare physician payment proposed in the Administration's Budget would be to reduce the Medicare economic index (MEI) to take into account a revision of housing cost estimates. The Academy is deeply concerned about the impact on family physicians of the proposed reduction in prevailing charge limits which would occur if the current method of calculating the MEI is replaced and the values reweighted from 1974. Reimbursement for services of family physicians already is low due to the bias toward inpatient and procedurally oriented care and against ambulatory and preventive care services. An adjustment to the MEI which would result in a freeze on or lowering of Medicare reimbursement would increase the inequities already inherent in Medicare reimbursement.

The recently released report of the Office of Technology Assessment, "Payment for Physician Services" confirms that the approved charges of family physicians, general practitioners and internists have been most constrained by prevailing charge limits. Additional reductions in the prevailing charge limits, such as those proposed by the Administration, will further penalize those physicians already receiving low reimbursement because of this imbalance in Medicare payment policy.

Data from Medical Economics (February 1986) notes that from 1980 to 1985, the inflation rate as measured by the CPI rose 37%. The article further states that the median annual net income for family physicians rose only 13% during that same time frame, while that of other physician specialists increased to a much greater extent (19% for internists, 25% for pediatricians and 37% for cardiologists). According to data provided by the AMA Socioeconomic Monitoring Service, the net income for surgical and medical specialties increased by 9.6% and 4.8% respectively between 1982 and 1983, while it decreased by 4.7% for family physicians/general practitioners. Medical Economics further reports that the already high overhead expenses of family practice have increased from 43 to 48% of gross income from 1980 to 1985, while that of other specialists was lower and increased by a smaller percentage, such as neurologists, whose overhead increased from 30 to 34% of gross.

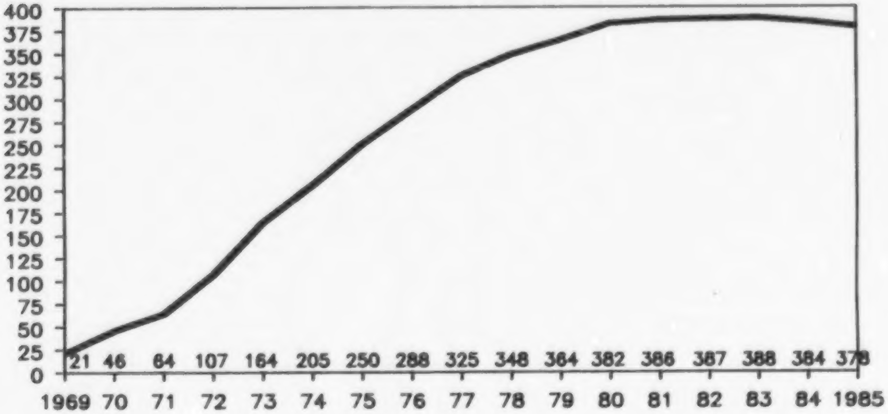
Administration efforts to restrain physician payment which do not acknowledge and address current distortions in Medicare physician payment policies are troublesome to this organization. A case in point is the implementation of a proposal in the budget calling for reductions in payments for procedures which are overpriced because of technological or productivity advances or because of geographic variations. We agree that there are inequities in the Medicare reimbursement methodology which result in excessive reimbursement for some procedures. However, inequities also result in deficient reimbursement. Yet the Administration, in regulations proposed to establish reasonable charge limitations, notes that "situations in which the reasonable charge mechanism results in a significantly deficient amount are virtually nonexistent." In reflecting on the proposals of the Administration to address excessive Medicare payments, we would urge Congress to consider all payment distortions--the excessively low as well as the excessively high.

As we have noted above, Medicare payment policies impact on the training of family physicians and on family physicians currently in practice. These payment policies have inherent in them inequities which are detrimental to physicians in primary care training programs and providing primary care services to the Medicare population. Further efforts by the Administration and Congress to restrain costs in the Medicare program should be sensitive to these concerns and should be crafted carefully to correct the historical imbalances described above, as well as to address the overall financial aspects of the Medicare program. A short term cost savings achieved to meet the budget targets must be evaluated in view of its long term policy implications for the health care of the American public.

AAFP REPRINT #150-B

ACCREDITED FAMILY PRACTICE RESIDENCIES

JULY 1985



The American Academy of Family Physicians

STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF NURSING

SUMMARY

AACN opposes the administration's plan to eliminate the Medicare passthrough for nursing education by regulation because:

1. Nursing students and faculty provide valuable care to Medicare beneficiaries, and
2. Cost studies are not currently available to demonstrate the schools, students, faculty and nursing staff that make use of passthrough dollars, and
3. It is inequitable to allow passthrough funding for medical staff while disallowing it for nursing personnel.

AACN is pleased that the Cost Study language in H.R. 3128 has been enacted, and that passthrough funding for nursing education will be preserved absent regulations to the contrary. In order to maintain the nursing education passthrough, AACN urges that Congress monitor the implementation of this legislation and advise the Administration to cease its attempts to eliminate passthrough support by regulatory initiative.

INTRODUCTION

This testimony is presented by the American Association of Colleges of Nursing, an organization representing 382 college and university schools of nursing. This organization exists to improve the practice of professional nursing through advancing the quality of baccalaureate and graduate programs, promoting research, and developing academic leaders.

Medicare (Title 18) was established to assure the provision of health care services to the elderly. The majority of Medicare services are provided in hospitals, nursing homes and private and public home health agencies. Since Medicare reimburses health care providers for services given to recipients, the government has a rightful interest in assuring that appropriately qualified health professionals provide service which is both of high quality and cost-effective. This interest has been recognized in the passthrough mechanism for hospitals where the bulk of care is provided. It is well known that nurses provide a large share of the professional health care rendered to the elderly in our society, and it must be assumed that nurses will continue to provide a large share of care to these recipients. Physicians alone cannot meet this need. Currently questions have been raised as to whether education of physicians, nurses and other health care professionals should continue to be subsidized by Medicare dollars and, if so, at what level of support. To ensure a continuing supply of qualified nurses to meet the health needs of Medicare recipients, in any redesign of Medicare regulations, support for nursing education must be maintained. In order to ensure that a rational approach to support of nursing education is applied, a cost study analysis of the nursing education activities reimbursable under Medicare should be completed. In addition, it is inappropriate to maintain Medicare support for one group of health care providers, physicians, while eliminating support for nurses, the group of providers who continue to be the major source of health care for the elderly.

RATIONALE

Practical experience in a clinical setting is a critical component of a nursing curriculum and the education of the nurse as health care provider. The justification for requesting support of the clinical training which occurs in nursing programs is concerned with the fact that clinical teaching cannot occur in the absence of service to patients. The inclusion of practical patient care experiences is central to clinical nursing education.

Students in the clinical setting are supervised by expert clinicians who provide both clinical mentorship to the students and expert service to the elderly. These faculty members do not receive reimbursement for the services provided to the elderly patient. Nursing faculty have not been included in fee for service arrangements. Their salaries are paid by schools of nursing. The time and effort spent by nursing faculty who supervise students in clinical experiences should be viewed as making a significant contribution to service. Students also provide needed services to elderly patients in the process of receiving their education in the service setting, but receive no payment for the care provided to patients.

Speculation exists that loss of Medicare support for nursing education would result in hospitals charging fees to students or educational institutions for the use of the clinical setting. Fees charged to the educational institution would result in the institution seeking financial support from other sources, such as passing on the increased cost to student, resulting in dramatic increases in the cost of a nursing education. Moreover, this increase in cost of nursing education to the student could result in further exacerbating already declining enrollments in nursing.

The amount of Medicare reimbursement for nursing education is uncertain, and studies to establish the cost of nursing education should accompany the establishment of rational policy regarding Medicare coverage of nursing education costs. The AACN is committed to studying the question of the cost of nursing education nationally and successfully competed as a subcontractor with Arthur Young for a contract to conduct a study to develop a cost estimating model for baccalaureate nursing education programs. This contract, granted by the Health Resources and Services Administration (HRSA), will allow the development of a cost estimating model through study of existing models of credit hour costs. Nursing education cost estimates will be produced based on current curriculum models and financial characteristics of baccalaureate nursing programs and their institutions.

The current estimates on the cost of Medicare support for nursing education range from $200 million to $350 million. Approximately 600 hospitals, and possibly more, receive Medicare support for nursing and allied health education programs. However, no accurate reporting mechanism exists for complete detailing of the Medicare nursing education expenditures. The variety of programs and the different cost reporting practices make quantification of actual costs very difficult. Currently, Health Care Financing Administration officials express concern that available data may be outdated and inaccurate, because of changes in the distribution of funds. In addition, the available data does not detail the types of clinical programs supported by Medicare. An accurate accounting of Medicare support for nursing education is essential and completion of the cost study mandated in H.R. 3128 will provide a basis for a rational policy of Medicare support for nursing education.

Currently, administrative rationale for deletion of Medicare support for nursing education is based in terms of an oversupply of providers. Although clear evidence exists that a growing physician surplus is emerging, no evidence supports a surplus of nursing personnel. On the contrary, in particular specialties there are serious shortages and maldistribution of nursing personnel. This is especially true for nurses with special training in geriatrics and long term care, in highest demand by medicare beneficiaries. Moreover, in some geographic areas, loss of Medicare support for nursing education could result in decreased nursing care services to the elderly Medicare patient as schools of nursing which are dependent upon this support are forced to decrease their program activities. Therefore, it is inappropriate to continue support of a profession in obvious oversupply while deleting support for the profession providing the bulk of health care to the elderly.

The AACN urges the Committee to reject the Administration's planned deletion of Medicare passthrough funding for nursing education in the Fiscal Year 1987. The AACN strongly supports the enacted cost study and pledges to work with the Committee in fulfillment of this mandate. Restructuring of Medicare reimbursement for nursing education should not inadvertently affect nursing services to the elderly.

JOINT STATEMENT OF THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS, AMERICAN DENTAL ASSOCIATION, AMERICAN ASSOCIATION OF HOSPITAL DENTISTS, AND ACADEMY OF GENERAL DENTISTRY

The American Association of Dental Schools, American Dental Association, American Association of Hospital Dentists, and Academy of General Dentistry appreciate this opportunity to comment on the Administration's 1987 Medicare budget proposals. Our comments address the potential impact on graduate dental education in hospitals of the Administration's proposals to eliminate direct medical education payments, and to reduce payments for indirect education costs to hospitals.

In our testimony we submit that

1. Most dental care in hospitals is provided primarily to patients who are aged, medically compromised or medically indigent

2. most patients served by hospital dental services often have few, if any, alternative sources of dental care in the community

3. the proposed reduction or elimination of Medicare support for graduate medical education not only harms the education programs but may eliminate the only sources of dental care for special needs patients including many Medicare beneficiaries.

Hospitals are Major Dental Care Providers

The first appointment of a dentist to a hospital medical staff occurred in 1791, but it was in 1901 that the first dental internship was established at Philadelphia General Hospital. Since then, hospitals have become major practice and teaching sites for dentistry. Almost 40,000 dentists in the nation have an appointment to the medical staff of at least one hospital. Currently, approximately 3,500 of the 4,700 JCAH-approved acute care hospitals in the nation provide some level of dental services. Of these, 957 have outpatient dental facilities.

Data from the American Dental Association show that over 7 million outpatient dental visits and approximately 350,000 dental admissions occur every year in hospitals. Patients who use hospital dental services usually have limited access to other sources of dental care in the community. The typical hospital dental patient may be aged, or handicapped, or medically compromised. These patients often have limited financial resources to pay for their dental care. Hospital dental services treat a disproportionate share of these special patients when compared to other dental care providers in most communities.

Hospitals are Major Dental Education Sites

Approximately 346 dental residencies are sponsored or cosponsored by Federal and non-Federal hospitals. These programs support over 1,400 training positions in dentistry. The majority of these programs are general practice residencies. These programs train dentists as primary care providers, skilled not only in dentistry, but trained in hospital settings to provide care to patients who require more complex services in a safe and supportive hospital environment. In addition to general practice residents, hospitals train practitioners in oral surgery, pediatric dentistry and other specialties. Moreover, many dental schools rotate third and fourth year dental students in hospitals. The clinical training of dental students in hospitals is about equally divided between inpatient and outpatient services. Students participate in activities including history taking, diagnosis, patient treatment, anesthesiology, and grand rounds.

Certain trends can be distinguished between graduate medical and graduate dental education. There are over 5,000 medical residency programs in more than 1,700 hospitals and health care facilities in the United States. Graduate medical education, however, occurs primarily in 100 major teaching hospitals. These hospitals train approximately 46 percent of all graduate physicians. Teaching hospitals represent less than 6 percent of acute care hospitals but they provide more than 47 percent of the nation's free medical care.

In contrast to medicine, graduate dental education programs occur in both hospitals and dental schools, but most school-based residents spend some proportion of time on hospital rotations. Graduate dental programs are smaller and more widely dispersed than their medical counterparts. There is substantially more primary care than specialty training in graduate dental education. One characteristic that graduate medical and dental programs share is the disproportionate amount of uncompensated care provided by these programs. Except for the allowable direct and indirect education costs attributable to dental residents, hospitals must rely on other sources of payment for dental care for Medicare beneficiaries. Hospital dental programs face a unique problem in providing care to Medicare beneficiaries. In addition to uncompensated care for the medically indigent, hospital dental programs provide dental care to Medicare patients, dental care that is not reimbursed by Medicare.

Financing Trends in Hospital Dental Training

Like most other segments of the health care industry, hospital dental practice has not been immune from the forces of cost-containment particularly the shift to a prospective payment system for hospitals. Dental departments in many hospitals have had the burden of managing and financing their own affairs thrust upon them by hospital administration. To achieve fiscal stability many hospitals have organized their staffs into group practices and stress productivity in educational programs. Others have limited care they provide to low-level payor groups or the amount of uncompensated care they provide while actively seeking patients who are healthy and financially able.

The cost/revenue factors related to dental education programs in hospitals have, in general, not been as easy to evaluate and adjust as have other segments of dental activities in hospitals. The reduction or elimination of some general practice residencies began about three years ago and may continue, indicating the current high-risk environment for these programs. The ADA Commission on Dental Accreditation has discontinued the accreditation of 40 general practice residency programs during the past three years at the request of the sponsoring institution. The most frequent and ominous reason for the request from non-federal institutions was loss of financial support for the residency programs.

Impact of Medicare Proposals on Hospital Dental Education

Hospital-based dental education programs are reliant on a fundamental principle in current prospective payment guidelines: that the net cost of approved educational activities is allowable for Medicare reporting purposes. Allowable educational costs for the profession of dentistry are those attributable to residency training programs approved by the ADA Commission on Dental Accreditation. To our knowledge, at least one dental school is challenging the denial by Medicare of costs claimed related to predoctoral dental education in its teaching hospitals. At the predoctoral level, reports from graduate dental education programs indicate that some fiscal intermediaries are denying reimbursement of any allowable costs attributable to dental residents. The AADS and AAHD are completing a project funded by the HHS Bureau of Health Professions to determine the impact of prospective payment systems on clinical dental education. The Bureau is the only other source of civilian Federal funding for graduate dental education. The Bureau provides seed money to establish general practice residencies which must ultimately become self sufficient. Because monies total less than $2 million per year they are not a significant source of financing to dental residencies.

Dentistry cannot afford further sudden or unexpected losses in Federal support of graduate dental education. As graduate dental programs and their parent hospitals adjust to forces affecting the nature and organization of hospital and related settings, neither can afford drastic disruption of critical sources of financial support for the training of future health professionals. Dentistry, in particular, must not be subsumed in policy decisions based entirely on their apparent impact on medicine. Dentistry does not have the overspecialization problems of medicine. The profession does not have the dilemma of struggling with the impact of foreign dental graduates on the delivery of its services. The profession has emphasized the graduate training of future general practice primary care providers skilled in treating the special needs of our changing population in appropriate medical facilities.

Dental educators and administrators are addressing the epidemiology of diseases of an aging population and its impact on the future of dental education. Dental schools and hospitals are jointly continuing their commitment to providing students an exposure to hospital-based health care. The survival of postdoctoral hospital-based dental education may depend critically on gradual policy development. This certainly applies to proposed modifications to Medicare reimbursement for graduate medical and dental education.

Therefore, our Associations recommend the following: (1) that there be no alteration in the range of health professions qualifying for reimbursement of eligible net costs of education under Medicare; (2) that direct education cost reimbursement continue; and (3) that there be no diminution of indirect cost reimbursement.

In conclusion, our associations appreciate the opportunity to comment on budget proposals affecting Medicare support for medical education. We offer our resources to the subcommittee as it develops policy concerning the future of Medicare reimbursement for education costs of health professionals.

STATEMENT OF

JOHN P. PAPP, M.D., F.A.C.G.

PRESIDENT OF

THE AMERICAN COLLEGE OF GASTROENTEROLOGY

Mr. Chairman and members of the Subcommittee on Health, The American College of Gastroenterology (ACG) is pleased to share with you our views and comments on the President's fiscal year 1987 budget proposals for Medicare reform. I am John P. Papp, President of ACG, and a practicing gastroenterologist in Grand Rapids, Michigan.

As we see it, federal health policy in this country is currently becoming fragmented and uncoordinated and is causing serious deterioration in the quality of care being delivered throughout our health system. The obsession with cost containment, combined with all of our reluctance to come up with a comprehensive plan to reduce costs while maintaining care has been the principle culprit.

During the past several years, the medical community has endured several of these cost saving cuts. The ax fell on physicians when a temporary Medicare fee freeze was imposed a few years ago. Thus far the freeze has not been lifted, while cost for physicians services to Medicare beneficiaries have continued to climb. Similarly, the imposition of the Hospital Prospective Payment System for medicare patients has certainly afforded little progress in our ability to provide top care to our nation's elderly population. Remember these are deserving beneficiaries that in many cases need the support of federal resources.

Mr. Chairman, at this time the medical community is able to provide an adequate amount of medical care to Medicare beneficiaries. Believe me it is not easy. But, as the federal contribution for medical care continues to shrink, something will have to give. At some point, the fine line between cost containment and reduced quality of care will be crossed. The sad part of this is that the line will be crossed at the expense of our nation's Medicare beneficiaries.

The American College of Gastroenterology believes the Medicare reforms proposed in the President's budget for fiscal year 1987 represents the crossing of the line. Plans to reduce funding for Graduate Medical Education will only insure that there will not be an adequate number of specialists trained to provide care for our nation's growing number of elderly. Increasing Part B premiums and raising Part B deductibles will only insure that fewer deserving aged individuals will seek and have access to the care they need. It is likely also that once a Medicare beneficiary finally does seek treatment for an illness he/she will be sicker and require more costly treatment. This is not within the realm of cost savings. Further maneuvers ratchet down and reduce payment will only insure a double-standard for treatment of Medicare patients. Already there is evidence that suggests that Medicare beneficiaries are being released from hospitals too early to assure an adequate recovery.

Several national organizations such as the American Medical Association and the American Society of Internal Medicine have suggested alternatives by way of raising revenues and reducing costs that make more sense than the current proposals to hit-up Medicare beneficiaries again. These include, for example, a doubling of the federal excise tax on alcohol and tobacco products. Studies show that an increase in these taxes would reduce consumption and in the long run spell out cost savings in health care expenditures. ACG would like to recommend that you take a close look at these alternative proposals before accepting the President's budget proposals that do not appear to be in the best interest of our nation's elderly.

Thank you for the opportunity to present our views.

STATEMENT OF
THE HOME HEALTH SERVICES AND STAFFING ASSOCIATION
AND
THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES

INTRODUCTION

The American Federation of Home Health Agencies and the Home Health Services and Staffing Association appreciate the opportunity to present comments to the House Ways and Means Subcommittee on Health on the issue of Medicare provisions in the Fiscal Year 1987 budget.

The American Federation of Home Health Agencies represents a cross section of Medicare-certified free-standing, official, Visiting Nurse Association, and hospital-based home health agencies. The Home Health Services and Staffing Association represents investor-owned taxpaying organizations which provide home health services and temporary staffing services through 1100 offices in 46 states.

Home health care is a humane and cost-effective alternative to institutionalization for elderly and disabled Americans. The home health benefit is inevitably growing as the population ages; as home health agencies develop the ability to care for more complex cases; and as Federal policies such as prospective payment for hospitals encourage the use of non-institutional services.

Despite strong Congressional and public support, we find the greater use of home care services cited as justification by the Health Care Financing Administration for excessive stringency in development of policies to govern the home health benefit. The Health Care Financing Administration's own statistics demonstrate that the growth in the benefit stems primarily from an increase in the number of beneficiaries receiving home health services rather than from higher per visit costs or from any significant increase in the number of visits per patient.

We believe that it makes no sense to pursue policies such as prospective payment which encourage deinstitutionalization, while reducing reimbursement and hindering the ability of home health agencies to deliver the medically necessary services which patients require upon discharge.

Mounting evidence all indicates an increased demand for more home health care of a greater intensity. A preliminary Government Accounting Office report to Senator John Heinz earlier this year indicates that Medicare patients are leaving the hospital earlier, and in a poorer state of health. Other studies have confirmed the "sicker and quicker" discharge phenomenon resulting from hospital prospective payment.[1]

In the last year, however, HCFA has initiated a series of actions which significantly reduce reimbursement, just as home health agencies are seeing more and sicker patients entering into the home health care system. Restrictive changes have issued from HCFA so rapidly that HHAs can scarcely adjust to one when several more are imposed. Many providers may be unable to bear the cumulative effects, especially with the additional problems posed for cost-reimbursed providers under the current one percent reductions mandated by Gramm-Rudman-Hollings.

A primary problem is the dramatic reduction in Medicare reimbursement, which will reduce reimbursement to home health providers by over five percent in 1986. We will discuss these changes in more detail shortly. In addition to reductions in reimbursement, HCFA is simultaneously imposing costly and time-consuming new burdens on HHAs. Agencies face a maze of confusing directives from their current fiscal intermediaries, and will incur additional expenses when they transfer to their new regional intermediaries. It is becoming increasingly apparent that a single new requirement for provision of "minimum" data elements, Forms 485-488, is enormously costly. Skilled professionals must complete these forms, reducing many highly skilled personnel to paper pushers. Currently, many fiscal intermediaries do not have the manpower to sort through this sea of paperwork which is flooding into their offices. The new HCFA forms show the tendency of Medicare funds to flow toward administration rather than to the provision of patient care.

At the same time, we have witnessed a sharp increase in the denial of home health claims. It appears that HCFA is attempting to create a climate of uncertainty for HHAs in the hope that rather than risk disallowances, agencies will arbitrarily cut back on the delivery of services, even though good medical practice would suggest that the visits should be made. The pressure to increase claims denials comes in part from HCFA's mandate to intermediaries to produce at least a five dollar return for every dollar expended for medical and utilization review.

[1] Prospective Payment Commission, February Report, 1986; Southwest Long Term Care Gerontology Center; Eastern Washington Area Agency on Aging.

As a result of restrictive reimbursement policies developed several years ago, the skilled nursing benefit is no longer available to many Medicare beneficiaries. The policies HCFA is implementing to achieve short-sighted savings in the home health benefit will only restrict the availability of home health services to still more beneficiaries. These policies include per discipline cost limits, a copayment for beneficiaries, bonding and escrow requirements, elimination of the favorable waiver of liability presumption, and the proposed elimination of the return on equity capital that has been allowed to home health agencies.

We urge you to look not just at the bottom line on savings projected for the next few fiscal years, but also to consider the impact on Medicare beneficiaries. Many whose access to home health care is restricted may have to be rehospitalized—at a much higher cost. Medicare certified home health agencies cannot provide services for which they are not adequately reimbursed. We urge you to consider the Medicare home health benefit within the context of the enormous savings achieved through shorter hospital stays and prevention of institutionalization for disabled and elderly Americans.

Per Discipline Limits

HCFA issued revised cost limits for HHAs last July, reducing reimbursement from the 75th percentile to 120 percent of the mean July 1, 1985, with further reductions to 115 percent of the mean July 1, 1986, and 112 percent on July 1, 1987. HCFA also moved from an aggregate to a per discipline application of the caps.

We remain particularly concerned about per discipline limits. In issuing the revised cost caps, HCFA indicated that application of the limits by discipline will result in about 70 percent of HHAs exceeding the caps in at least one service. This represents over 3600 agencies, an extraordinarily large number. HCFA acknowledged that reducing the limits for future years below 120 percent of the mean will affect even greater numbers of HHAs.

HCFA suggested that most HHAs are inefficiently operated, but provided no data to support this contention. We firmly believe that the vast majority of agencies are managed in a cost effective manner. Certainly there may be some home health agencies that could be operated more efficiently, but HCFA could not document that inefficiency is a problem. The likely consequence of a precipitous drop in the caps and application on a per discipline basis is going to be a loss of access to services and a reduction in the quality of care for Medicare patients.

Since HHAs are cost reimbursed, there is no profit in providing services to Medicare beneficiaries and no incentive to continue provision of over-cap disciplines. Many HHAs no longer able to offset over-cap services with savings achieved in other disciplines will cease furnishing services when over the limits. HHAs most often find themselves over limits in medical social work and the various therapies. They are over caps for a variety of factors beyond their control:

- the disproportionate allocation of administrative and overhead costs to less frequently used services, based on the cost of providing visits in a discipline rather than on how much of the administrative and overhead expenses are actually attributable to that discipline
- the scarcity of therapists
- payment of salaries adequate to attract and retain therapists in rural areas
- the need to offer full time employment to therapists and MSWs in order to secure their services, even though an HHA does not have the equivalent of a full time work load in a particular discipline
- the need to compensate therapists for travel time in rural areas and for the increasing amount of time that they must devote to paperwork requirements

If HHAs are unable to offset losses on over-limit services with below-cap disciplines, an agency administrator will have several options:

- discontinue over-cap services
- take losses out of his/her salary
- secure a bank loan, the interest of which is reimbursable by Medicare
- hire an accountant, whose expenses are reimbursable by Medicare, to shift costs--completely in accordance with the law--to below-cap services
- increase utilization of over-cap services, for example by requiring all counseling to be performed by a MSW rather than routinely by skilled nurses
- shorten time spent with patients and thus reduce the quality of services provided
- discharge highly paid experienced personnel and replace them with lower-salaried employees

Copayments

The Administration projects a savings of $100 million in FY 1987 and $640 million between Fiscal Years 1987 and 1991 by requiring patients to share the cost of home health services. HCFA would impose a copayment equal to one percent of the inpatient hospital deductible for the first 100 visits in a calendar year on patients not being treated for a condition for which they have been hospitalized or confined to a skilled nursing facility. The copayment would equal approximately $5 in 1986.

We believe that implementation of this copayment would have a detrimental effect on Medicare beneficiaries without resulting in significant savings to the Medicare program.

The coinsurance provision would impose an additional financial burden on the elderly who are already experiencing hardship because of previously enacted Medicare cuts. Currently, senior citizens are paying for more than 40 percent of their own medical expenses, and are now spending more of their income on health care than they did before the enactment of Medicare in 1965. A home health copayment will cause many elderly and disabled patients to forego badly needed health care rather than incur additional debt. If home care services are terminated prematurely, these beneficiaries will be at higher risk of requiring hospital or nursing home care.

The savings the Administration projects for the copayment proposal are more apparent than real. Under Medicare statutory and regulatory provisions, copayments that cannot be collected from beneficiaries will be reimbursed as bad debt. Section 1861(v) of the Medicare Act precludes providers from shifting the cost of services provided to Medicare beneficiaries to other patients.

In addition, the copayment proposal would place an administrative burden on home health agencies to collect relatively small amounts of money. Notwithstanding that the amounts to be collected for each patient will be relatively small, the cost of collecting $50 in coinsurance is as great as the cost of collecting $500. To establish that a copayment is uncollectable, home health agencies must attempt several collection efforts including telephone or personal contact with the patient or individual responsible for the patient's bills. These efforts to collect add to the agencies' administrative expenses which are Medicare reimbursable. Moreover, Medicare regulations permit providers to use collection agencies for uncollected coinsurance. The administrative expenses of collection agencies are also reimbursable under Medicare.

Bonding and Escrow

HCFA has recently issued proposed regulations on bonding and escrow that will have a serious impact on small home health agencies, forcing a number of them to close their doors. Disabled and elderly Americans in rural and underserved areas will pay the price in loss of access to crucial health care services. Many small urban agencies will also be at risk. Numerous areas throughout the country have but a single home health agency serving the needs of Medicare patients. For each one of these agencies forced out of business by HCFA's ill-advised proposal, there will be beneficiaries left with few alternatives. Their choices will not be happy ones: admission to a hospital, at greater expense to Medicare; placement in a nursing home, though many areas of the country have no skilled nursing beds available; or searching for substitute care, though the patient is homebound and debilitated.

Small agencies have minimal capital assets or corporate resources to use in securing a bond and most are not in a position to establish an escrow account of the size HCFA would require. It is easy for HCFA to say HHAs can go out and secure a bond, but bonding companies will be extremely reluctant to issue bonds to providers with few tangible assets to pledge. If the owner has few substantial assets, or has them tied up in a mortgage, it would be nearly impossible to secure a bond. In addition, the cost of obtaining a bond on personal assets, if one could be obtained, would be substantial. Any costs associated with this requirement would not be reimbursable by Medicare.

Small HHAs are already facing uncertain times with reduced cost limits, massive new paperwork requirements, a pending switch to new FIs, an upsurge of denials, and erratic behavior from intermediaries under pressure to meet denial quotas.

HCFA proposes bonding and escrow for the following:

- o agencies less than three years old, those with new owners, and agencies applying for participation in Medicare;
- o HHAs which have had a significant overpayment, defined as 15 percent of Medicare costs, within the previous three settled cost reports; (It makes no difference if the HHA is making repayment, with interest.) and
- o HHAs with a high Medicare utilization rate, defined as 85 percent or more of visits provided. (Agencies which can demonstrate that they are not financial risks will be exempt.)

This proposed regulation is an unfortunate example of overkill, a burden that cannot be justified by any conceivable threat to the Medicare Trust Fund from home health. HCFA's action appears to be motivated by a desire to reduce utilization of home health services by forcing a number of HHAs out of business.

The legislative authority for the bonding and escrow requirement is contained in the Omnibus Budget Reconciliation Act of 1980 which states that the Secretary of Health and Human Services has the authority to set requirements, including bonding and escrow for home health agencies, that may be necessary to insure the financial security of the Medicare Trust Fund. The evidence indicates that bonding and escrow of the scope that HCFA proposes in not necessary. The home health industry has an unequaled record of fiscal responsibility, a bad debt rate far below that of every other business and industry we know of. HCFA's own Bureau of Program Operations has indicated that the default rate on home health overpayments since 1965 is miniscule—only fifteen hundredths of one percent (.15 percent). Statistics provided by HCFA to justify the bonding and escrow regulations are vague, and we believe for good reason. The numbers simply do not justify a requirement of this scope and impact. We suspect that more detailed figures would not support HCFA's massive remedy for what is a statistically insignificant "problem"; otherwise they would have been provided.

In justifying the sweeping nature of the proposed regulation, HCFA says "...the health status of some beneficiaries could be jeopardized by the interruption of services because of the unexpected closure of an HHA." The most likely reason for the closure of an agency, if HCFA proceeds with this ill-advised regulation, will be the unreasonable nature of the requirement itself, which will bring about the very consequence HCFA claims to be trying to prevent.

Waiver of Liability

HCFA issued final regulations on February 21 to eliminate the favorable waiver of liability protection for HHAs, skilled nursing facilities, and hospitals, effective March 24, 1986.

Under the favorable waiver presumption, HHAs with a quarterly denial rate of 2.5 percent or less are paid for denied services if it is determined that the HHA did not know or could not reasonably have known that the services either were not reasonable and necessary or constituted custodial care.

Congress instituted the current waiver presumption in 1972 to protect Medicare patients whose care falls into an area of subjective judgment, and Medicare providers which need the protection in order to render services falling into the grey areas. The waiver presumption also protects the beneficiary and provider during the subjective decision-making process of the fiscal intermediary.

Home health agencies are cost reimbursed. They have limited capital resources to fund visits not covered under waiver of liability. The uncertainty of the current climate makes waiver protection all the more crucial. HCFA now proposes to hold HHAs to a 100 percent standard of accuracy, while acknowledging a 32.4 percent rate of reversal on appeal for HHA denials. Agencies all over the country are receiving inconsistent and unclear directives from intermediaries. The majority of HHAs will be transferred to new FIs in FY'87, exacerbating the denial problem for providers trying to adapt to the policies of a new intermediary.

We have a number of cases, illustrated on the attached chart, which demonstrate seriously ill beneficiaries who were judged by a FI not to be sick enough to receive the home health services their physicians ordered. Many of these beneficiaries were, however, sick enough to be hospitalized and sick enough to die. But fiscal intermediaries determined that in the interim between hospitalization and death, they were not entitled to the services their physicians ordered for them. (This survey information was first presented to the House Select Committee on Aging at a hearing on July 9, 1985.)

Return on Equity

HCFA has proposed elimination of the return on equity capital for proprietary home health agencies. This proposal demonstrates a fundamental misunderstanding of the role of equity capital in the establishment and maintenance of home health agencies. While it is true that HHAs are labor-intensive rather than capital-intensive, return on equity remains crucial for the start-up and operating funding of many agencies. Return on equity was intended to compensate investor-owned providers for legal and tax advantages available only to public and not-for-profit agencies, such as: Federal, state, and local government funding; tax-deductible gifts; and exemption from property, franchise, and income taxes. A return on equity is needed to maintain all types of providers on an equal footing, and to avoid discrimination against investor-owned agencies.

Although home health agencies do not require the same magnitude of capital investment that a hospital or skilled nursing facility requires, capital is still required for the start-up and modernization costs of an agency (purchase or leasing of buildings and equipment, etc.) as well as for ongoing operating costs such as covering outstanding accounts receivable. HCFA's actions to delay payments to providers by fiscal intermediaries exacerbates the problem of outstanding accounts receivable and increases the need to rely on equity capital. The importance of equity capital will be increased as providers are forced to rely on capital resources in order to meet payrolls and other operating expenses during delays in Medicare payments. HCFA's proposal to require a substantial percentage of home health agencies to obtain bonds or establish escrow accounts would also increase the capital needed to operate a HHA. Furthermore, agencies also require capital to modernize their facilities and operations. The need to modernize may also be driven in large measure by other HCFA requirements, such as the proposal to require computerization in order to receive periodic interim payments (PIP).

The estimated savings from eliminating return on equity for investor-owned home health agencies ($7.5 million, according to HCFA's estimate) is proof of a significant impact on the provider community. And for providers who manage to cope with this impact, savings to Medicare will be more than proportionately reduced, since equity capital will be replaced by commercial loans at a much higher cost to the program.

Furthermore, legislative history reveals that elimination of return on equity is inconsistent with Congressional intent to include in Medicare reimbursement such indispensable costs of doing business for investor-owned providers.

If return on equity is to be eliminated, it should be phased out over a period of several years, and tied to implementation of a prospective payment system.

Return on equity has been an essential part of Medicare reimbursement since shortly after the program was enacted. Proprietary companies and investors rely on it in calculations regarding opening and maintaining agencies. The sudden elimination of return on equity would create confusion in the financial community, with a concurrent adverse impact on the stocks of publicly traded companies.

We believe that developments with respect to hospital reimbursement could serve as a reasonable precedent for treatment of return on equity for other types of providers. The latest Administration proposal for treatment of capital and return on equity for hospitals calls for reduction in return on equity payments over three years. This proposal would also reduce funded depreciation for non-profit hospitals. Such a proposal may be appropriate in a prospective payment system because the payment is initially established on the basis of current costs, and rewards providers for their efficiency. Efficient providers can then use the money saved to reduce their need for other capital. At present however, home health agencies are reimbursed on a cost basis which, unlike the hospital prospective payment system, does not allow providers to retain any difference between their costs and the Medicare payment level. Eliminating return on equity at this time would disallow an item of necessary cost incurred by these providers even if they are efficient enough to provide care within the cost limit constraints.

CONCLUSION

In the wake of a steady stream of regulatory changes issuing from HCFA, the home health benefit has entered a period of great uncertainty. We are led to wonder if those in charge of the Medicare program are serious about providing health services to homebound beneficiaries. There is now an urgent need for Congressional action to stabilize the benefit before any further disruption is added to the recent litany of regulatory changes and additional paperwork requirements. We need a moratorium on any further regulatory proposals from HCFA until we can adjust to the policies of our new fiscal intermediaries and to the numerous changes thrust upon us in the last year or so.

Some HCFA actions must be reversed if home health services are to remain available to all disabled and elderly Americans who need them. Specifically, we urge Congress to:

- o Allow home health agencies to apply cost limits in the aggregate. HCFA attributes a savings of only $14 million over three years to per discipline application of the caps. A provision to allow aggregation of the limits was included in the Omnibus Budget Reconciliation Act of 1985, but was dropped from the bill by the House of Representatives, under pressure from the Office of Management and Budget. We urge your support for legislation to allow aggregation of cost limits and for efforts to maintain adequate reimbursement for Medicare home health visits.
- o Reject the Administration's proposal for a copayment on home health visits.

- Urge HCFA to delay action on its bonding and escrow proposal until development of a final regulation carefully targeted to those home health agencies that have demonstrated that they constitute a financial risk to Medicare.
- In the event that Reconciliation does not become law, cosponsor and support Rep. Roybal's H.R.4065 to preserve the favorable waiver of liability presumption for one year after the new fiscal intermediaries begin operations.
- Cosponsor and support Rep. Roybal's H.R.4330, which among other provisions would provide an up-front review process to help replace waiver of liability one year after the ten regional intermediaries begin operations, by providing early notification to providers on the eligibility of patients for home health services and approval or disapproval of the type and frequency of services ordered. The Roybal bill would also require FIs to process claims in a more timely and accurate manner, or risk financial penalty or even termination of contract. We believe that Rep. Roybal's Medicare Continuing Care and Quality Assurance Act of 1986 would go a long way towards stabilizing the home health benefit.
- Maintain return on equity for proprietary home health agencies until a prospective payment system for home health agencies is implemented, and then phase it out gradually.

We look forward to working with you to help preserve the home health benefit for our nation's elderly and disabled citizens.

DATA PREPARED
FOR
HOUSE SELECT COMMITTEE ON AGING

JULY 9, 1985

SUMMARY

The American Federation of Home Health Agencies conducted a survey of 5000 Medicare certified home health agencies in March to obtain cases to illustrate the impact that loss of waiver of liability would have on home health providers and Medicare beneficiaries We received 401 cases of total or partial denial of home care services provided over the last two years.

Currently home health agencies with a denial rate of 2.5 percent or less can be paid for denied services if it is determined that the home health agency did not know or could not have known that the services were not reasonable and necessary, or constituted custodial care. The Health Care Financing Administration issued proposed regulations (Federal Register, February 12, 1985) to eliminate in effect waiver of liability protection for HHAs, skilled nursing facilities, and hospitals.

The attached cases are precedent setting for HHAs providing home health services denied in whole or part, but covered under waiver of liability. If the favorable waiver presumption is lost, presumably in the future, patients of the type illustrated here would not be able to receive the home health services their physicians order. Although these cases are intended to illustrate specifically the waiver of liability issue, they indicate that there are seriously ill Medicare beneficiaries who are not receiving the home care services they need.

In 1983, the last year for which we have figures, an estimated 1,320,000 Medicare patients received home health care. Eighty-five percent of HHAs are on waiver, with a denial rate of less than 2.5 percent; 32.4 percent of denials were reversed at reconsideration by fiscal intermediaries.

A number of cases not reversed are appealed to adminstrative law judges and to the Federal Courts. Between October 1, 1984, and February 28, 1985, administrative law judges decided 840 cases involving Part A Medicare denials. Denials were reversed in 57.6 percent of these cases. (We have not been able to break down this figure by type of provider.)

The 401 cases we received came from 32 states, with patients ranging in age from 26 to 98. The number includes 38 disabled beneficiaries; the others are elderly patients with a median age of 78.

A disproportionate number, 39 percent, come from just three states--Florida, Illinois, and Georgia. Ninety-nine percent have multiple diagnoses; many are extremely debilitated and have an ailing elderly spouse or live alone.

The most frequent diagnoses are cancer, cardiac and circulatory ailments, and complications of diabetes.

Attached we have provided a chart of 50 cases from all areas of the country, illustrating the range of circumstances we found:

- patients who recovered with home health care, and others who ended up being institutionalized or who died
- post hospital and nursing home patients, and those with no prior institutionalization
- denial of all services, denial for a period of weeks or months, and denial of a portion of services during the whole course of care

Of the 50 patients on the attached chart:

79 is the median age

12 received denial of all home health services

12 lived alone

35 are post hospital cases

13 had to be (re)institutionalized

19 died

SAMPLE CASES

Mid Atlantic - An 82 year old widow living alone in a rural area, suffering from bowel obstruction, acute urinary tract infection, dehydration, gall stones, and degenerative joint disease; on multiple medications. During three week course of care with home health agency, intestinal problem stabilized and patient was given nutritional instruction. All visits were denied on the basis that services could be performed by a nonmedical person. Subsequent to discharge, patient was readmitted to hospital with another bowel obstruction.

Midwest - 76 year old patient with colon cancer which had spread to the liver. He was admitted to home care after discharge from the hospital. He had a Hickman Catheter for chemotherapy that required daily flushing and weekly sterile dressing changes; also had a urinary catheter and required care for a hip incision. The patient deteriorated, was rehospitalized, and died. Four of twelve nursing visits provided to this dying patient prior to rehospitalization were denied as not reasonable and necessary.

South - A 92 year old patient with acute infected lesions and growths following removal of skin cancer on scalp, face, neck, and hands. Also suffered from angina, arteriosclerosis, hypertension, and crippling arthritis. This elderly beneficiary lived alone, had poor eyesight and hearing, was inadequately nourished, confused, and incapable of caring for self. The intermediary allowed services for the first and third months of care, but denied services in the second month, claiming that the services could have been provided by a nonmedical person. The patient's condition was most acute in the month for which all care was denied.

South - 84 bedridden woman suffering from kidney failure, but not on dialysis; she also had congestive heart failure, high blood pressure, lung congestion, lupus, and severe hip pain. She deteriorated steadily and entered hospital for treatment of these conditions. Upon discharge, home health services were covered for five days, then all were denied on the claim that care could be provided by a nonmedical person. The patient was readmitted to the hospital and died two days later.

South - 83 year old patient with terminal cancer of the liver, weight loss, a draining biopsy site, urinary tract infection, constant nausea and vomiting, coughing up blood, and mental confusion. Patient's 79 year old wife unable to care for him because of stroke and coronary condition. Patient's condition slowly deteriorated, requiring frequent medication changes, and wound care. Beginning five weeks after admission to home care services, the intermediary denied all visits, claiming that the services could have been effectively and safely provided by a non-medical person. The patient died shortly after services were denied.

West - 88 woman with terminal cancer, a fractured hip, skin ulcers, and congestive heart failure. Patient, who lived alone, was discharged from hospital to home care; agency worked with family members in the area to keep her home. All home health services were denied; according to the intermediary, this beneficiary did not require skilled nursing care. Consequently, patient had to be admitted to a nursing home where her condition deteriorated and she died.

West - 87 year old man with chronic obstructive pulmonary disease and high blood pressure. Because of blindness, deafness, and death of his wife during the course of care, patient needed visits for safety, monitoring of treatment compliance and potassium level in blood, and chest drainage treatments. This man was stable and independent until services were denied, on the claim that skilled care was not required. Patient died one week after services were denied. Agency was told appeal would do no good. Intermediary said "Write your Senator."

MEDICARE HOME HEALTH CARE DENIALS

50 SAMPLE CASES

CASE #	AGE SEX (IF KNOWN)	DIAGNOSIS PRIMARY SECONDARY - SIGNIFICANT COMPLICATIONS	PERTINENT MEDICAL & SOCIAL FACTORS	SERVICES ORDERED BY PHYSICIAN *	SERVICES DENIED	FISCAL INTERMEDIARY'S REASON FOR DENIAL	OUTCOME (IF KNOWN)
12	82 F	bowel obstruction acute urinary tract infection (UTI) gall stones osteoarthritis dehydration	post hospitalization lives alone in rural area on multiple medications	RN 2x week for lab work, diet teaching, treatment of UTI and severe diarrhea	all services	non medical person could perform	rehospitalized with another bowel obstruction; prognosis poor
13	74 F	cancer of breast, metastasized to spine and rib cage diabetes hypertension urinary tract infection arteriosclerosis	post hospitalization confusion, leading to non compliance with treatment on multiple medications lives with unmarried son	RN daily HHA 3 x week; for packing and treatment of mastectomy wound and other conditions	18 of 30 RN visits for one month	non medical person could perform	wound slowly improved
16	73	terminal bronchial cancer diabetes anemia hypertension stricture of esophagus	lived with daughter who works' had gastric tube; on oxygen needs assistance with daily activities; weak; difficulty walking	RN 5x week HHA 5x week; for tube feeding and dressing change to tube site	2 of 5 weekly HHA visits	medically unnecessary	rehospitalized; died four weeks later
22	83 F	acute respiratory infection congestive heart failure chronic brain syndrome fecal impactions severe diarrhea dehydrated	lives with elderly spouse very confused bed bound poor living conditions	RN 1x week HHA 3x week	all services	condition appears to be regulated within acceptable limits	hospitalized; died
63	83	small strokes colitis cataracts dehydration asthma anemia kidney disease arteriosclerosis congestive heart failure	post hospitalization lives alone depression on multiple medications	RN 4 consecutive days, tapering off to 1x every 2 weeks	all but first 4 RN visits for 2 month period	not reasonable and necessary	improved, discharged
64	70	pneumonia GI bleeding skin ulcers rheumatoid arthritis congestive heart failure hypertension arteriosclerosis histal hernia	post hospitalization anxiety on mulitple medications	RN 2x week, then tapering off	all but 1 RN visit	not reasonable and necessary	died
78	68 M	3rd degree burns both legs diabetes chronic obstructive pulmonary disease edema urinary tract infection	post hospitalization obese patient, infirm wife, and immature grandchild unable to perform dressing changes	RN daily; for dressing change on burn sites	all but 1 RN visit weekly	patient had been instructed in dressing technique	complications avoided
79	74 F	breast cancer, metastasized to lungs monthly chemotherapy treatments edema	post hospitalization lives alone greatly weakened serious falls at home	RN weekly; for nutritional, respiratory and post chemotherapy instruction and monitoring	all RN visits after first four months	not skilled service	

91	[illegible] M	colon and liver cancer hip fracture with pinning periodic chemotherapy treatments lung congestion constipation	post hospitalization confined to bed or wheelchair wife mentally and physically incapable on multiple medications Hickman catheter for chemotherapy	HHA 3x week RN 3x week for dressing changes, daily irrigation of Hickman catheter and Foley catheter, bowel management, monitor vital signs, pain control, drug response	4 of 12 RN visits	not reasonable and necessary	rehospitalized; died
113	84 M	ulcer base of spine Parkinson's disease organic brain syndrome	lives with elderly wife who has cardiac condition bed bound totally dependent	RN every 1-2 weeks HHA 2x week	all services	non medical person could have performed	died
114	83 M	congestive heart failure arteriosclerosis diabetes edema	post hospitalization lives alone progressively weaker multiple medications	RN 1 every 2 weeks HHA 2x week	all services	non medical person could have performed	died
120	70 M	cancer of larynx; laryngectomy wound infection post surgery for lesion on lung fistula of esophagus chronic lung disease arteriosclerosis	post hospitalization patient and wife extremely anxious, overwhelmed tracheostomy tube suction machine and catheter tube feeding	HHA 3x week RN daily tapering off to 1x week for wound and tube care, instruction to patient and family	4 of 11 RN visits	inappropriate utilization	
121	70 M	vascular surgery, embolectomy deep open wounds each leg hip replacement severe allergic reaction to transfusion	post hospitalization on multiple medications	RN daily 2x week tapering off after that	6 of 19 RN visits for third to seventh week on service (denials reversed)	overutilization	leg wounds healed slowly
132	88 F	terminal cancer hip fracture ulcer of sacrum congestive heart failure	post hospitalization lives alone in severe pain	RN 1x week HHA 2-3x week	all services	did not require skilled nursing care	with denial of home health services, had to enter nursing home; died
134	87 M	chronic obstructive pulmonary disease hypertension	blind; poor hearing recent widower	HHA 1 every 1-2 weeks RN 1x month for percussion and postural drainage, monitor potassium level and compliance	all services	did not require skilled nursing care	died within a week of denial
135	88 M	skull fracture urinary tract infection, degenerative joint disease diabetes	progressive debilitation severe hearing loss dependent for daily needs	RN 1x week for teaching, lab tests, gait training	all services	skilled care not required	died
136	82	stroke, unable to swallow skin ulcers malnutrition GI bleeding leg amputation congestive heart failure lung congestion	bedbound with restraints confused multiple medications incontinent; Foley catheter Dobbhoff tube caregiver friend slow to comprehend	RN 2-3x week and as needed HHA 3x week	25 RN visits 4 months (denial of HHA visits reversed)	number of visits not reasonable and necessary	hospitalized

137	70 F	end stage chronic obstructive pulmonary disease	husband died during 3rd month of care unable to care for self hired live-in companion on oxygen	RN 1-2x week for lab work, monitor medications and congestion	all visits after 10th week	non medical person could have performed	died (2 days after last visit)
138	83 M	terminal cancer of liver urinary tract infection coughing up blood draining biopsy site weight loss unrelieved nausea and vomiting	mental confusion elderly wife suffering from stroke, heart condition multiple medications	RN 1-2x week HHA 1-3x week	all services	non medical person could have performed	hospitalized; died
[illegible]	[illegible] F	colon cancer with metastasis inflammation of stoma nausea and vomiting edema	post hospitalization lived with elderly spouse post chemotherapy bedridden incontinent	RN 2x week HHA 3x week	7 of 8 RN and 4 of 12 HHA visits	did not require skilled nursing care	patient improved
140	84 F	kidney failure; not on dialysis lupus heart failure hypertension lung congestion ulcers on heels	post hospitalization bedridden cannot be left unattended Foley catheter severe hip pain	RN 2-3x week HHA 1-2x week	14 RN and 3 HHA visits; all visits after first days post hospital	non medical person could have performed	rehospitalized; died
143	78 F	post craniotomy and partial removal of small intestine hydrocephalus with partial paralysis; abdominal shunt kidney failure partial intestinal obstruction cerebral deficiency; stroke diabetes; anemia cellulitis of legs	multiple hospitalizations elderly spouse totally dependant Foley catheter, tube feedings	RN 3x week tapering off HHA 5x week tapering off	3 RN and 6 HHA visits (denial of HHA visits reversed)	not reasonable and necessary	
156	75 M	terminal bone cancer with metastasis ulcer at base of spine	post hospitalization severe weakness incontinent in severe pain; elderly wife unable to prepare injections for pain; grandchild unwilling continuous deterioration	RN 3x week or as needed	9 of 14 RN visits for second month on service; allow 1 per week	duplication of family care	died end of third month on service
181	85	congestive heart failure arteriosclerosis infected leg ulcer	multiple hospitalizations decrepit residence poorly educated on multiple medications	RN 1x week	all visits	not reasonable and necessary	ulcer improved
182	83 M	stroke with partial paralysis ulcer on hip severe dermatitis	post hospitalization bedbound, in fetal position elderly ailing spouse	RN 1x week HHA 2x week	all visits	not reasonable and necessary	
185	80 M	acute congestive heart failure acute pulmonary edema blood clots in eye vertigo rapid heartbeat	post hospitalization patient and spouse very apprehensive on multiple medications on oxygen	RN 3x week tapering off	7 of 9 visits	not reasonable and necessary	
187	75 F	acute psychosis; paranoid, withdrawn, fearful arteriosclerosis unstable hypertension rapid heartbeat organic brain syndrome	post hospitalization confused her multiple medications; possible overdoses; medication changes abandoned by inpatient relative	RN 2x week HHA 3x week	17 RN and 35 HHA visits for 3rd - 5th months on service	not reasonable and necessary	steady progress; markedly improved upon discharge
205	79 M	prostate and bone cancer	post hospitalization lived alone weight loss; poor appetite weakness increasing pain suffered blackout with head injury	RN 2x week, reducing to 1x week HHA 3x week PT 2-3x week for 1 month MSW 1-2x month	1 of 3 HHA for 3rd month all services 4th - 5th months	supportive care; not reasonable and necessary	died in 6th month of care

224	82 F	diabetes congestive heart failure (CHF) leg amputation for gangrene edema	post hospitalization and nursing facility blind changes in medication	RN 1x month for monitor diabetes, medication changes, signs of CHF, skin problems and edema; compliance with diet	all visits	not reasonable and necessary	
230	73 M	lung cancer chronic obstructive pulmonary disease arteriosclerosis osteoarthritis drug allergy skin ulcer vomiting blood	severe weakness and shortness of breath on oxygen confused, hostile, hallucinations	RN 3x week, reduced to 1x week, increase to 2x week following hospitalization	all visits after third week	not require skilled nursing care	died
		malnutrition bleeding ulcer of esophagus anemia urinary tract infection leg abrasion	post hospitalization extremely weak weight declined to 75 pounds on multiple medications	RN 1x week and as needed HHA 3x week	3 RN, 9 HHA visits for 2nd/last month	inappropriate utilization	
244	80 M	post surgery for dislocation of shoulder stroke cerebral atrophy diabetes pulmonary fibrosis osteoporosis	post hospitalization lives alone has been extremely independent	RN 2-3x week HHA 4-6x week for 2 weeks, then decrease PT 2-3x week	16 of 26 HHA visits	not reasonable and necessary (f.i. stated patient should have been in nursing home)	rehabilitated
247	78 F	perforated cancer of colon, colostomy diabetes	post hospitalization weakness poor nutrition rapid deterioration	RN 3-4x week HHA 2-3x week	22 RN and 20 HHA visits	non medical person could have performed	rehospitalized died
271	95	post surgery for fractured hip arteriosclerosis kidney infection edema	out of nursing home deaf alone during day multiple medications	RN 2x week, reduced to 1x week HHA 3x week x60 days	4 RN and 11 HHA visits	no acute changes necessitating home health care	progressed to walking with walker
281	76 F	congestive heart failure diabetes arteriosclerosis edema	multiple hospitalizations multiple medications; confused her medications sporadic acute symptoms	RN 2-3x week	all RN for 12th and 13th months	not reasonable and necessary	rehospitalized; died in month following denied home health services
286	77 M	post abdominal surgery cancer of colon continuous GI bleeding decreased heart rate	post hospitalization frequent change of multiple medications extremely weak	RN 3x week MSW 2 visits	5 RN visits	not reasonable and necessary	
287	92	arteriosclerosis organic brain syndrome glaucoma severe fungal infections of feet	blind lives alone bedridden extremely weak	RN, HHA, PT, OT 2-3x week (PT for ambulation)	9 PT visits	not reasonable and necessary	became stronger
294	80	heart attack surgery for nasal cancer diabetes hypertension	post hospitalization confused constant chest pain incontinent	RN 3x week and as needed	10 RN visits in 2 months after admission	no acute changes necessitating home health care	
296	69	cancer of kidney urinary tract infection anemia hypertension small strokes cardiac irregularity; elevated potassium level post stomach and abdominal surgery GI bleeding anorexia lung congestion	on multiple medications incontinent extreme weakness acute symptoms	RN 3x week	51 RN visits over 4 months	chronic condition; no acute changes	
298	75	cancer of colon; colostomy cancer of liver and lungs infection of incision	post hospitalization	RN daily x2 weeks tapering down to 2x a week	9 of 18 visits (denials reversed)	not medically necessary	

305	72 M	amyotrophic lateral sclerosis chronic obstructive pulmonary disease dehydration inability to swallow	several hospitalizations oxygen dependent rapid deterioration	RN 1x week	all RN visits in 2nd month (denials reversed)	non medical person could have performed	hospitalized; died
[illegible]	[illegible] M	arteriosclerosis history of urinary tract infection incontinent; had Foley catheter; skin open and draining heart attack congestive heart failure	post hospitalization and nursing home on multiple medications	RN 1 every 1-2 weeks HHA 3x week	2 RN and 11 HHA visits in 3rd month (denials reversed)	not reasonable and necessary	
338	84 F	draining sacral skin ulcer metastatic lung cancer	post hospitalization on multiple medications	RN 1x week and as needed HHA 3x week	all RN for 3rd-6th months	not require skilled care	
346	74 M	cancer of prostate removal of testicles urinary tract infection periodic radiation therapy	post hospitalization severe depression weak in pain steady deterioration no appetite	RN 3x week decreasing to 2 HHA 4x week decreasing to 3	15 RN visits	non medical person could have performed	rehospitalized
362	79 M	cancer of lung, liver, pelvis chemotherapy treatments degenerative joint disease	post hospitalization primarily bedridden elderly anxious spouse	RN 2x week PT 2x week HHA [illegible]x week	all visits	not require skilled care	died
364	70 M	quadriplegia hypertension degenerative osteoarthritis	lives alone, no family bedridden alcoholic	PT 3x week	2 PT visits per week	not reasonable and necessary	learned to transfer from bed
369	80 M	acute abscess of thigh post surgery on thigh cardiac irregularity	post hospitalization disabled elderly spouse on multiple medications pain and shortness of breath	RN daily for wound packing and irrigation, monitoring vital signs, medication and nutrition guidance HHA 3x week	42 RN visits in 4th and 5th months after rehospitalization	not reasonable and necessary	condition very unstable
371	81 F	amyotrophic lateral sclerosis tracheostomy post partial removal small intestine gastrostomy with tube feedings	post five month hospitalization respirator dependent Foley catheter spouse unable to cope with care suction machine on multiple medications condition terminal	RN daily HHA 7x week	10 RN and HHA visits in first month	not reasonable and necessary	
388	85 F	cancer of uterus and lung post lung surgery pernicious anemia anorexia	post hospitalization lives alone generalized weakness insomnia, pain, anxiety	RN 3x week tapering off	all visits after first 10 days	non medical person could have performed (all denials reversed)	
389	92	infected skin lesions of scalp, face, neck, hands; dermatitis, keratosis post surgery removal of skin cancers hypertension arteriosclerosis; angina arthritis small strokes	lives alone poor vision and hearing diminished mental capacity unable to care for self inadequate nutrition	RN 2x week tapering off HHA 5x week increasing to daily to treat infections	all visits after 3rd week (denials for 3rd month reversed)	non medical person could have performed	infection cleared; discharged

* RN - skilled nursing
HHA - home health aide
PT - physical therapy
OT - occupational therapy
MSW - medical social work

STATEMENT OF THE AMERICAN NEPHROLOGY NURSES' ASSOCIATION
GERALDINE BIDDLE, PRESIDENT

PATIENT SAFETY AND QUALITY OF CARE

Program reductions already in place have produced many changes in the location of dialysis facilities and in the provision of care. Many facilities have moved to out of hospital locations, reuse of dialyzers has increased to more than 50% of facilities, and more cost effective mixes of staff have been created. Additionally the cost of equipment has been reduced through major efforts at group purchasing. Concurrently, many health related equipment companies have left the dialysis market. It is widely recognized that today equipment costs have been reduced as far as they can go. Likewise, overhead has been trimmed with the movement to out of hospital locations, leaving labor as the prime target for any further cost reduction.

Specifically, proposed reductions in ESRD payment rates will encourage program administrators to promote reductions in professional nursing positions. Ironically, reductions in registered nursing positions which are already taking place occuring in at a time when more nursing care and supervision is needed, not less.

Dialysis patients are on the average an older and bigger population. Today the mean age of incenter dialysis patients is 52 and rising according to the Network Coordinating Ccouncil/MIS facility survey for 1984. A large percentage of patients are in the seventh and eighth decade of life. (The survey indicates the following distribution of patients by age coming into the program in 1984: 25.3% were 60 to 69 years of age, 22.2% were 70+, and 18.7% were between 50 and 59 years of age.) Elderly patients are frequently treated in chronic dialysis units from the onset of illness untill their death, since they are generally not suitable for transplantation. These patients are on the average quite fragile, experiencing the effects of illness as well as the problems of aging. They are often unable to make or report observations of their own health status that would, if it were known to the professional dialysis team, influence decisions about the administration of heparin and other intravenous substances. Clearly these patients are usually dependent on their care givers.

ESRD is not a benign stable disease and as such it is inappropriately characterized as a stable condition, even though the dialysis patient has a life threatening spectrum of illnesses. There is a tendency to consider dialysis as a maintenance or routine treatment, a view that is thus reflected in practice by the delegation of nearly complete responsibility for the procedure to nurses and technicians. The delegation of this responsibility, however, should only be given to those professionally prepared to accept and be held accountable for such responsibility. Only the nephrology nurse of all non-physician health care providers can carry out these responsibilities.

Dialysis patients have multiple diagnoses as well as complications of renal failure: cardiovascular disease, including hypertension, severe atherosclerosis and its sequelae, pericarditis, congestive heart failure, arrhythmias and miocardial infarction are commonplace. Severe diabetes is also one of the leading causes of renal failure. While the onset of complications is often subtle, the potential for catastrophic events while on dialysis is quite real, regardless of setting. Obviously these patients need a careful assessment of their status at each dialysis.

The nephrology nurse is educated beyond the basic of generic professional nursing. Nephrology nurses have skills and expertise in recognizing the signs and symptoms that accompany various disease processes and possess the capability of performing physical assessments on high risk patients prior or during each dialysis. Additionally nephrology nurses have primary responsibility for quality assurance activity and patient and staff education.

Conditions of participation for hemodialysis facilities provide minimal standards for staffing requirements. Often, though, the requirements are satisfied by the presence of a single nurse during dialysis who may, in fact, be "supervising" the care of more than 40 patients. The regulation of June 3, 1976, Subpart U - Conditions of Coverage of Suppliers of ESRD Services, Section 405.2162 (b) Standard: on-duty personnel reads: "Whenever patients are undergoing dialysis, other than self-care dialysis, one currently licensed health professional (eg., physician, registered nurse, or licensed practical nurse) experienced in rendering ESRD care is on duty to oversee ESRD patient care, and an adequate number of personnel are present to meet the needs of patients, and an adequate number of personnel are readily available to meet medical and non medical emergencies."

This regulation is totally inadequate in meeting the needs of the dialysis patient population. Further, there is no stipulation that the "currently licensed professional" be physically present in the dialysis unit during treatment.

Significant in staffing can be accomplished through staff mixtures. However, in the absence of the presence of a physician, adequate numbers of registered professional nurses must be available for each dialysis shift. This is essential for patient safety and for the provision of an acceptable level of care.

We are not experts in economics. We are advising you, however, as experts in the nursing care needs of renal failure patients. Registered professional nurses who are educated and experienced in assessing patient status and responsiveness to treatment, planning patient care which involves much more than planning the parameters of an individual dialysis treatment, implementing that care and evaluating the outcome on an ongoing basis are essential to the ESRD program. Limiting access of nephrology nurses to dialysis facilities will lead to an even more costly program than the one that exists today. The needs of renal failure patients with multi-system involvement will go unrecognized, and unmet and may lead to hospitalization that will in turn create increased cost in the program you are trying to limit today.

Composite rates under prospective payment have achieved the very results anticipated by the government when it adopted the program. However, further reductions threaten the safety and well being of patients through the potential loss of professional nursing. We strongly urge you to consider the regulation of June 3, prior to implementation of any further program reductions.

TESTIMONY OF

Leonard D. Goodstein, Ph.D.

Executive Officer

The American Psychological Association

On behalf of the American Psychological Association and its 76,000 members and affiliates, I am pleased to have this opportunity to present our views on the Administration's FY 1987 budget proposals for the Medicare program.

The APA has a long history of interest in and concern for the Medicare program since its adoption in 1965. Medicare helps to assure that health care services are available for the elderly and disabled, populations with which psychology as a discipline and profession has a long-standing interest. Various divisions of APA reflect this concern, most notably the Divisions of Clinical Psychology, Psychologists in Public Service, Adult Development and Aging, Rehabilitation Psychology, Community Psychology, Counseling Psychology, Psychopharmacology, Mental Retardation, Health Psychology, and Clinical Neuropsychology.

Our general reaction to the Administration's FY 87 proposals for Medicare is that it reflects a general willingness to abandon commitments in areas that we believe fall most appropriately in the domain of the federal government. The first of these is that, when the prospective payment system was established, the government recognized that Medicare patients benefit from clinical education programs for health professionals, and to that extent, specifically allowed targeted payments to support medical education.

The Administration's budget proposes to reform payments for direct medical education by eliminating payments for all health profession training for nonphysicians and certain overhead costs associated with classroom training. We object to the inequity of continuing support for physician residents and interns, for whom there exists a documented surplus, and not allowing it for other health professions. The available supply of nonphysician health professionals varies by profession and limited examples of excess supply do not apply uniformly to all nonphysician providers.

Currently, the direct medical education mechanism permits stipend support to psychologist interns in medical school-affiliated hospitals and some salary support to psychologists who are medical school faculty members. The elimination of these payments could jeopardize the provision of psychologists' services, such as testing, assessment, and special therapy techniques -- many of which are used for the care of disorders prevalent among the elderly such as dementia, Alzheimer's disease, and depression. The Reconciliation package recently passed by Congress for Medicare contained a conference agreement on the need for " attention to nursing and other health professions educational activities which Medicare reimburses hospitals for." Therefore, we urge a thorough examination of the impact of the direct medical education payments on training programs for nonphysicians and the role of these programs in relation to care provided to Medicare patients before any reforms are made.

Our second concern is the proposal to set payment for some physician procedures and equipment at "inherently reasonable levels" where the market rate is judged lower than the current Medicare payment rate. At this point, the services to which this could apply remain undefined. It could easily serve as the basis for a less than systematic way to reduce reimbursement rates. Any limitation of physician reimbursement could adversely affect physicians' ability to use non-physician health professionals, including psychologists. The cost for physician's services, and for all other Medicare services, must be kept under control. However, caution should be exercised in reimbursement level adjustments so incentives do not act to unduly limit the use of necessary services.

Our third concern is the proposal to gradually increase the Part B premium to cover 35% of program costs (now 25%) by 1991. The Administration states that low income beneficiaries would not be affected because their premiums are paid by Medicaid. In the first place, this proposal continues the past focus of the Medicare program on requiring consumers to pay a greater share of total costs while no attention is given to designing a benefit package that could effectively result in controlled or decreased costs. Of particular concern is the design of the mental health benefit, where insufficient levels of coverage often exacerbate the likelihood of inappropriate and inefficient use of medical services.

The Administration proposes to limit FY 87 Medicaid payments to $1.3 billion below current service outlay estimates. If Medicaid must pay the additional costs of increased Medicare premiums, it could inhibit states' ability to provide current levels of service availability. Such a burden on Medicaid could affect mandated service levels; optional programs such as mental health services could be disproportionately affected.

In addition to these specific comments, we note that the Administration's 1987 budget proposal assumes that the prospective payment system for hospital services will be fully implemented by 1987. This may be unwarranted, since the Reconciliation package passed recently by Congress specifically requests a one-year extension in the transition to a national reimbursement rate. A pause in transition would result in different budget projections for the Medicare program.

We appreciate this opportunity to present our views on the Administration's FY87 Medicare budget. We look forward to working with the Congress to achieve reforms in the Medicare program that will ensure that adequate and appropriate services are delivered to Medicare enrollees.

STATEMENT

# of the

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS

The American Society of Clinical Pathologists (ASCP) is pleased to have this opportunity to comment on the Administration's budget proposals for FY 1987 and their impact on laboratory professionals. ASCP is a nonprofit medical specialty society organized for education and scientific purposes. Its membership numbers over 45,000 board-certified pathologists, other physicians, clinical scientists and certified technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel. ASCP's certifying board registers over 140,000 certified laboratory professionals annually.

There are three initiatives proposed by the Administration which are of particular concern to the Society and are under the jurisdiction of the House Ways and Means Health Subcommittee: 1) elimination of the direct pass-through to hospitals for allied health education; 2) freeze in reimbursement for clinical laboratories at the present level; and 3) introduction of "reasonable cost limits" in reimbursement for hospital outpatient testing via regulation.

The Administration's FY 1987 budget calls for the elimination of Medicare's direct pass-through to hospitals for allied health education via regulation. ASCP requests that Congress prohibit the Administration from singling out allied health for cuts through regulation. Maintenance of these funds to hospitals is essential to the future of hospital based allied health programs such as Medical Technology. The impact of Medicare's Prospective Payment System on hospitals has been profound. The specific impact on the clinical laboratory, turning a profit center into a cost center, has severely affected Medical Technology programs on a national scale. According to the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS), there were 694 Medical Technology programs throughout the United States in 1982. There are presently only 575 programs open today. In other words, there has been a reduction of over 17% in Medical Technology programs from 1982 to 1986, and this trend is continuing. The bulk of the closures have occurred since the enactment of the Prospective Payment System.[1] Directors of those programs which remain open have stated that their existence depends upon continued federal support. Hospitals cannot afford to maintain these programs without this support.

A recent study by the AMA's Commission on Allied Health Education and Accreditation listed employment for medical technologists and medical technicians at the bottom of the list of those positions which provided moderate job entry incentives (as estimated by appropriate income, responsibilities, and "attractiveness of opportunity"). The impact on allied health programs include: 1) termination, or future termination, of clinical affiliations; 2) alternative mechanisms for clinical experience (i.e., less practical experience in the hospital laboratory); and 3) reductions in the amount and quality of time spent with laboratory students.

Experience tells us there is a manpower shortage for Technologists on the horizon. As there are fewer programs available, high caliber students will not be attracted to the profession and, consequently, there will be fewer qualified laboratory professionals available to provide quality health care throughout the United States. Recent Medicare reimbursement changes have made salaries and working conditions (i.e., longer hours) for laboratory professionals less attractive, driving many highly qualified individuals out of the field. Federal initiatives to increase the number of allied health programs, should this need reach critical proportions, is an expensive proposition which could be avoided.

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[1] Closings: 1982 - 12 schools of medical technology
1983 - 12 schools of medical technology
1984 - 26 schools of medical technology
1985 - 43 schools of medical technology
1986 - 26 schools of medical technology (as of April)

The Administration's FY 1987 budget also calls for a statutory freeze on the clinical laboratory fee schedule at the present level. It is ASCP's position that a fee freeze for laboratory testing would be particularly unfair at this time. The 1984 Deficit Reduction Act mandated a 40% reduction in laboratory fees in the creation of a new payment methodology. Unlike cuts to other health providers, this reduction was not a cut in the amount of increase in the reimbursement level, but a real reduction in Medicare payment to laboratories. Laboratories are still trying to adjust to this new, reduced reimbursement method. A freeze in reimbursement at the present level would cause an additional heavy burden on the industry and would make it more difficult for laboratories to meet increasing costs without shifting those costs to other insurers.

The Deficit Reduction Act of 1984, which included hospital laboratory outpatient testing under the same fee schedule as nonhospital testing settings, provided that this testing would revert to cost based reimbursement in 1987 if Congress does not act to include them in the national fee schedule. The Administration proposes to impose reasonable cost limits in reimbursement for hospital outpatient testing by regulation, thereby taking the decision about treatment of hospitals out of the hands of Congress. Congress, in creating this provision, demonstrated its concern about the impact of this new reimbursement system and the 40% cut in lab fees on top of Medicare's Prospective Payment System on the hospital. GAO was commissioned to study the issue and make recommendations to Congress on the inclusion of hospitals in a national fee schedule for laboratory testing. The study is due January 1987, and any regulatory action to change the reimbursement methodology for hospital outpatient testing prior to that date would be premature and extremely disruptive to an industry which has experienced so many changes and cuts over the last three years.

ASCP strongly urges the House Ways and Means Health Subcommittee to prohibit the Administration from enacting any regulatory changes in reimbursement for the direct pass-through for allied health education and in the reimbursement methodology for hospital outpatient testing services. Furthermore, the ASCP requests that Congress not legislate a freeze on the clinical laboratory fee schedule, thereby allowing laboratories to continue their adjustment to the lowered fees mandated by the 1984 Deficit Reduction Act. ASCP appreciates this opportunity to express its views to this Subcommittee and is most willing to provide further information for the record if requested by any members.

AMERICAN SOCIETY OF INTERNAL MEDICINE
STATEMENT
ON
THE FY 1987 BUDGET
TO THE
WAYS AND MEANS COMMITTEE
March 25, 1986

OVERVIEW AND SUMMARY

Unless Congress can come up with a reasonable alternative, the proposed FY 1987 cuts in federal spending on health will do irreparable harm to the quality and availability of medical care in this country.

This is the conclusion of the American Society of Internal Medicine (ASIM), as well as most other organizations dedicated to preserving high quality medical care. Since 1981, ASIM has supported reasonable approaches to moderating federal expenditures on health. For example, the Society was the first medical organization to support a temporary freeze on Medicare payments for physician services.

But over the last five year, health programs in general--and the Medicare and Medicaid programs in particular--have absorbed a disproportionate burden of reducing the national deficit. So far, the commitment of physicians, hospitals, and others to providing services more efficiently and effectively have, by and large, protected patients from serious harm. Inevitably, however, a point will be reached when improved efficiency alone cannot save sufficient money. Reductions in the

availability and quality of medical care will be the only recourse. ASIM is concerned that this point is rapidly approaching.

Already, there is growing evidence that patients are being prematurely discharged from hospitals under Medicare's prospective pricing system. This dangerous trend will be exacerbated as the Administration continues to ratchet down on payments to hospitals. Physicians, too, also are reporting that it becoming more and more difficult to continue to provide the highest quality of care possible to Medicare patients for the amounts allowed by Medicare. A substantial number of internists, for example, have been forced to move to a dual fee schedule: one for private patients and one frozen at the level mandated for Medicare patients. Most have expressed considerable reluctance about being forced into doing so, on the basis that over time there may be a natural tendency to treat Medicare patients differently (and perhaps not as well) as private patients.

No physician or hospital wants this to occur. But is it reasonable to expect that anything else can occur if the federal government continues to phase out its commitment to supporting the best possible medical care for the American people? High quality medical care always will carry with it a high price. Unfortunately, based on the Reagan Administration's budget proposals, it appears that this Administration is not willing to pay that price.

For these reasons, ASIM strongly urges the House Ways and Means Committee to oppose further cuts in federal spending on health, particularly on Medicare and Medicaid. ASIM will assist the Committee in any way it can in making the case against continued cuts in federal spending on health.

ASIM is acutely aware, however, of the necessity to eliminate the federal deficit. In our view, there are reasonable alternatives. In addition to seeking savings in other parts of the budget that have not been targeted for a disproportionate share of cuts in the past, ASIM believes there is a need to seek sources of additional revenue.

One such source of revenue--which is consistent with good health policy--is to reduce all forms of support for tobacco and other harmful products. Specifically, ASIM strongly supports (1) doubling the federal excise tax on tobacco and alcohol products, (2) eliminating the tax deductibility of advertising for tobacco products; and (3) phasing out federal subsidies for the growing of tobacco. These measures will produce significant revenue for the federal budget--while helping to reduce the harmful effects on health associated with the use of tobacco. Furthermore, ASIM believes that Congress should consider a major restructuring of Medicare's financing and benefits structure in order to bring more revenue into the program, to improve benefits, and to restore long term solvency.

ASIM believes that the basic approach in the Domenici-Chiles budget resolution recently adopted by the Senate Finance Committee--increased revenues, fewer cuts in health programs, and more equitable distribution of cuts--is preferable to the administration's FY 1987 budget. The Society urges the House of Representatives to enact a budget resolution with a similar emphasis on spending priorities.

COMMENTS ON SPECIFIC BUDGET ITEMS

Physician Reimbursement Reform

Under the heading "selective physician reimbursement reform," the Administration proposes several regulatory initiatives designed to decrease spending on Medicare Part B services.

The Administration specifically proposes to "recalibrate" the Medical Economic Index--which limits increases in prevailing charges according to how much the Health Care Financing Administration (HCFA) has concluded overhead costs have increased since 1971--by lowering the housing component of the MEI. Although the Administration has not yet published a notice of how it plans to implement this budget item, it has been suggested that this will result in an increase in Medicare prevailing charges on January 1, 1987, of 1 percent or less.

ASIM believes the proposed recalibration of the MEI, in effect, is an indefinite continuation of the Medicare fee freeze. On March 1, 1985, all physicians--as a result of Gramm-Rudman--absorbed a 1 percent decrease in Medicare prevailing charges. Under the recently enacted Budget Reconciliation Act of 1985, the vast majority of physicians who have chosen to be "nonparticipating" will continue to have prevailing charges frozen at the June 30, 1984 level, minus this 1 percent reduction. Therefore an increase of 1 percent or less on January 1, 1987, will result in the prevailing charges for those physicians remaining at or below the June 1984 levels through December 31, 1987. This means, in effect, that prevailing charges for the vast majority of services rendered to Medicare patients (i.e., services rendered by nonparticipating physicians) will be paid at least through December 31, 1987, at the "actual charge" levels in effect in calendar year 1982. (This is because the June 30, 1984 prevailing charges were based on charges submitted during calendar year 1982, or earlier if the Medicare Economic Index applied.)

It is clear that a five year gap between Medicare allowances and actual charges will create incentives to decrease the quality and availability of services to Medicare beneficiaries. During the past five years, physician overhead costs have increased measurably. From January 1982 through December 1984, the Consumer Price Index increased by 11.7 percent (all items) and by 14.5 percent (all services). From 1982 through 1985, physicians' average overhead costs increased by 18.1 percent.

Given the likelihood that physician practice costs will continue to increase at a steady rate, the proposed recalibration of the MEI is likely to mean that the rate of increase in Medicare prevailing charges will fall farther and farther below actual fees charged by physicians, actual increases in physicians' overhead costs, and payments by other third-party payors. In this respect, the Administration's proposal is worse than a congressionally-mandated fee freeze, since it guarantees for the indefinite future that Medicare payments will not be realistic given what is actually occurring in the marketplace. Moreover, since the Administration proposes to do this administratively, Congress will have no direct opportunity to review whether or not this reduction in Medicare benefits serves the interests of beneficiaries.

Ultimately, a continued erosion in the value of Medicare benefits will force compromises in the quality and availability of services provided to patients who are Medicare beneficiaries. As prevailing charges continue to fall behind the actual cost of providing services, physicians will be faced with some difficult and unpalatable choices. One choice--already adopted by a large number of physicians--will be to move to a dual fee schedule: a higher fee schedule for private patients and a lower one for Medicare beneficiaries. This creates a clear danger that over time Medicare patients will be treated differently, and perhaps not as well, as non-Medicare patients.

A second potential response, equally unpalatable to most physicians, will be to close their doors to seeing any more Medicare patients than are currently being seen in their practices. Economic realities will dictate that those physicians with high Medicare patient loads will suffer disproportionately compared to those with younger, healthier patients insured by private insurance plans. A smaller number of physicians may decide not to treat Medicare patients at all. Either response--closing their doors to additional Medicare patients or dropping out of the program altogether--will create severe obstacles to the availability of high quality medical care for patients who are Medicare beneficiaries.

A third response will be to ask Medicare patients to pay more for their services directly out of pocket. Increased out-of-pocket costs might occur in several ways:

o Nonparticipating physicians may decrease the number of times they accept assignment on services rendered to Medicare patients, thus reversing the trend to date of increasing assignment rates.

- Physicians who are currently participating may revert to nonparticipating status, since the proposed recalibration of the Medicare Economic Index will apply to their services as well as to those rendered by nonparticipating physicians.

- Once the freeze expires, nonparticipating physicians may increase their actual charges to beneficiaries. On any unassigned claim, this would mean that the patient would be forced to pay more out of pocket to cover the gap between Medicare's payment and the actual charge.

A fourth response may be to decrease administrative services currently provided by physicians free of charge to Medicare patients. For example, many physician offices complete claims for all Medicare patients, regardless of whether or not the claim is assigned or unassigned. As overhead costs increase, however, physicians may be forced to reduce administrative staff and discontinue unessential administrative services that represent additional practice costs.

A fifth response may be to increase the quantity and complexity of services billed to the Medicare program. A recent study found that physician price controls are not effective in curbing increases in program costs, due to increases in the number of services provided and in the complexity of services (Rice, T.H. Reducing Public Expenditures for Physician Services: The Price of Paying Less).

Finally, a likely response to continuing a virtual freeze on Medicare payments--but one that will be most strongly resisted by the medical profession--will be to decrease the quality of services provided to patients who are Medicare beneficiaries. This may occur through subtle changes in practice patterns, such as spending relatively less time with Medicare patients compared to other patients. Or it may occur more directly, by declining to provide certain necessary services to Medicare patients if the payment levels do not cover the actual costs of providing the service.

Physicians strongly object to being placed in a position of being forced to make such choices, none of which are in the best interests of patients. The medical profession has already absorbed four years of increased costs with no increase in Medicare payments for their services, while managing to maintain the same standard of quality medical care expected by patients who are Medicare beneficiaries. At the same time, physicians have been able to increase assignment rates to all time high. It is unrealistic, however, to expect that physicians can indefinitely absorb the shortfall resulting from arbitrary limits on Medicare prevailing charges without changing the way that Medicare patients are treated.

For these reasons, ASIM strongly urges Congress to mandate legislatively that the Administration not proceed with its plans to recalibrate the Medicare Economic Index or to otherwise extend the existing fee freeze through regulation. Only a clear statement by Congress to this effect, ASIM believes, will be sufficient to prevent the Administration from implementing this dangerous proposal.

Moreover, physicians who provide primarily office based services--such as internists and family physicians--will be disproportionately harmed by an extension of the fee freeze under the guise of recalibrating the MEI. Cognitive services provided by office based physicians--such as office, nursing and home visits--have been hurt to a greater extent under the Medicare fee freeze than lower overhead procedural services. Traditionally, Medicare payment levels have undervalued cognitive services in comparison to procedures. This disparity has been demonstrated by numerous studies, including a 1979 study funded by the Health Care Financing Administration which concluded that a two- to three-fold disparity exists between payments for cognitive services and surgical procedures under the Medicare program (Hsaio and Stason, Toward Developing a Relative Value Scale for Medical and Surgical Services). This conclusion was reaffirmed by a more recent study in Massachusetts (Hsaio and Braun, Resource Based Relative Values of Selected Medical and Surgical Procedures in Massachusetts). Not coincidentally, office based physicians are also the ones that bare the greatest burden of increasing overhead costs. Therefore, ASIM strongly believes that Congress and the Administration should exempt office, nursing, and home visits from continued restrictions on increases in Medicare prevailing charges, such as a proposed MEI recalibration.

For example, one alternative might be to apply the proposed MEI recalibration only to inpatient services. ASIM believes, however, that although some relief for office-based cognitive services is essential, it is far preferable that Congress and the Administration impose no further across-the-board limits on Medicare payments for any physician services. If such limits are to be imposed, however, exempting selected cognitive services will at least minimize some of the harmful effects of this approach.

Reducing payment for services priced at a level that is not "inherently unreasonable"

The Administration also has proposed, by regulation, to reduce payment for services that are priced at a level that is determined to be "inherently unreasonable."

Since 1983, ASIM has supported the concept that charges and allowances for new procedures should reflect changes over time in the resource costs, (such as expertise, time, liability risks, special training and development costs) required of physicians performing a service, and has urged members to adopt this principle in establishing charges for procedural services. ASIM supports reasonable and fair approaches to accomplish this objective.

ASIM, however, is strongly concerned that the Administration's approach may result in "inherently reasonable" determinations driven strictly by budget concerns, with insufficient attention to the effects of revised payment rates on beneficiaries. For this reason, ASIM has urged the Administration to withdraw its recent notice of proposed rulemaking (NPRM), as well as Transmittal 1115 which instructs carriers on local application of the inherently reasonable criteria. ASIM believes that a new notice of proposed rulemaking should be published only after the Administration has had adequate consultation with representative physician, beneficiaries and members of Congress on application of the inherently reasonable criteria, and only after major modifications are made in the Administration's approach to this issue. Attached to this statement is a copy of the comments ASIM submitted on the NPRM. We respectfully request that it be included in the record of this hearing.

There is also considerable question whether or not the Administration, under current statute, has the authority to proceed with promulgating this regulatory initiative. Therefore, ASIM believes that Congress must clearly state its intent that HCFA and local carriers not proceed with use of the "inherently reasonable" criteria to reduce payment levels, unless some strong safeguards are included in the process. Specifically, as noted in ASIM's comments in the NPRM, HCFA should be required to:

- Consult on an ongoing basis with an appropriate physician group in determining how inherent reasonableness should be applied to specific procedures. For example, Congress could require HCFA to consult with the Physician Payment Assessment Commission, recently enacted by Congress, on any proposed "inherent reasonableness" determination.

- Develop an appropriate formula to allow legitimate adjustments in proposed national fee schedules or caps on payment based on quantifiable differences by locality by the cost of practice. The MEI is not suitable for this purpose, since it does not differentiate in practice costs by locality, nor does it accurately reflect the true practice costs incurred by physicians. HCFA should consult with physician organizations in developing the new formula.

- Make available for public review and comment the reasons why it was determined that a procedure was overvalued or undervalued and the data used to make the determination.

- Use inherently reasonable criteria to adjust payment for undervalued, as well as overvalued, services.

- Mandate the establishment by carriers of physician advisory groups to provide ongoing input on inherently reasonable determinations on the local level.

- Require carriers to make available for public review and comment the reasons and data behind an inherently reasonable determination with a sufficient specified comment (minimum 90 days).

- Describe in any future NPRM any other criteria, procedures, etc. to be used by carriers in making inherently reasonable determinations.

- Authorize carriers to make payment changes for services determined to be undervalued, as well as those determined to be overvalued.

ASIM believes that only with substantial changes of this nature can physicians and beneficiaries be assured that inherently reasonable determinations will be made on a fair and rational basis, rather than strictly to reduce programmatic expenditures. The Society is concerned that the Administration will not, on its own, make satisfactory changes in its approach to this issue in any future proposed or final regulations governing use of inherently reasonable by HCFA and its carriers. Therefore, given the considerable uncertainty whether or not HCFA even has the authority to promulgate this regulation, ASIM believes that Congress must clearly express its intent that any statutory authority to make "inherent reasonableness" determinations is contingent upon incorporating sufficient safeguards into the process, as described above.

Need for long term reform of the system of payment for physician services

ASIM believes that the Administration's so-called "selective physician reimbursement reforms" are a far cry from the type of comprehensive, long term reform required to improve Medicare's system of payment for physician services. In fact, proposals such a recalibrating the Medical Economic Index are precisely contrary to real reform, since they lock in existing inequities in the system of payment, such as the disparity in reimbursement between physicians cognitive and procedural services.

ASIM has repeatedly urged Congress and the Administration to adopt proposals for long term payment reform. Specifically, ASIM believes that Congress should mandate development and implementation within a reasonable period of time a new system of payment that would include the following elements:

1. The new system should consist of a schedule of allowances based on a resource cost relative value scale, in lieu of the existing "customary, prevailing and reasonable" charge system. The Health Care Financing Administration recently awarded a contract to Harvard University to develop a resource based relative value scale. This project provides the means for developing a consensus on more appropriate relative values for physician services, based on the amount of time required to provide the service; the complexity of the service; physicians' investments in professional training and education; overhead factors, including the cost of liability risks; and other appropriate resource cost factors that may be identified through this study. Once a resource based relative value scale is developed, it will be a fairly simple matter for the Medicare program to determine the appropriate conversion factors--based on budgetary and fiscal objectives among other factors--for each service included in the RVS. Since a resource-based relative value scale will reflect differences in the time and complexity of various services, it will not be necessary to differentiate by specialty in determining conversion factors.

2. Conversion factors applied to a resource cost relative value scale to create a schedule of allowances should vary appropriately according to an index that accurately reflects differences in the current cost of practice in various parts of the country. ASIM believes that geographic differentials in fees may

be appropriate, but only to the extent that such differentials can be justified by legitimate differences in the cost of practice in different parts of the country. Unless there are clear differences in the cost of practice, such differentials cannot be justified. Under a schedule of allowances based on a relative value scale, legitimate differences in the cost of practice can be recognized by allowing different conversion factors for different parts of the country. The schedule of allowances could then be updated each year to reflect changes in the cost of practice, according to a new cost of practice index that accurately reflects changes by locality in practice costs over time. This same cost of practice index could be used in making inherent reasonable determinations, as described earlier.

3. If physicians in a particular region are dissatisfied with the local conversion factor as adjusted by the cost of practice index, there should be an opportunity for physicians to negotiate with the local intermediary for a more appropriate conversion factor. Such negotiation should be limited to negotiating an appropriate conversion factor to more accurately reflect the true practice costs in the locality, not to re-negotiating the relativity between and among physician services. ASIM believes that the opportunity to negotiate over conversion factors is desirable, since it is likely that any conversion factor determined solely by HCFA according to a mathematical formula may, in some cases, fail to reflect some legitimate practice cost differences in a given locality. This particularly would be the case if HCFA arbitrarily limited increases in conversion factors for budget reasons, or failed to implement promised updates in payment levels.

4. The relative value scale should be updated on an annual basis as new procedures enter the system. The overall relative value scale should be reevaluated at three year intervals to reflect changes in the resource costs required to perform certain services. Conversions factors should be updated annually to reflect changes in the cost of practice index.

5. Once a resource based relative value scale is developed, the new schedule of allowances based on resource costs should be phased in as rapidly as feasible (i.e., over a three year period to allow time for physicians to adapt to the new payment schedule).

6. Physicians should continue to have the right to establish their own fees and either accept--or not to accept—the amount of payment identified by the schedule of allowances. An indemnity system of this type that will allow patients to shop around for those physicians whose charges are competitive with the amount allowed under the schedule of allowance.

In addition to the above, ASIM believes that Medicare beneficiaries should continue to have the option of enrolling in capitated payment systems, such as health maintenance organizations. For this reason, ASIM supports appropriate voucher legislation, although the Society has some significant concerns over the Administration's proposed legislation to expand the existing voucher option.

Moreover, ASIM is committed to developing recommendations on such important issues as medical practice variations, "bundling" of physician services, incentives to accept assignment, and strengthening peer review of physician fees and practice patterns. ASIM's Board of Trustees recently approved a substantial commitment of

ASIM resources toward developing recommendations on those important areas. The Society would be glad to share with Congress its findings and recommendations as soon as they are available.

Most importantly, ASIM believes that long term, comprehensive reform of this nature is far preferable to continued reliance on arbitrary, short term budget cuts to achieve savings. The Society would welcome the opportunity to work with the Ways and Means Committee on developing legislative proposals for long term change in the system of payment for physician services.

OTHER BUDGET PROPOSALS

In addition to the proposals affecting physician payment discussed above, ASIM has concerns and recommendations on other items in the Administration's budget. Our recommendations are discussed below.

Freeze in clinical laboratory fees

ASIM opposes the Administration's proposal to freeze clinical laboratory fees. If enacted by Congress, this proposal may threaten the ability of physicians and independent labs to provide laboratory services, with an adverse effect on the availability of timely laboratory results to patients. At the very least, ASIM believes that Congress should require a study of the impact of this proposal—as well as the provision included in the Reconciliation Act of 1985 to mandate assignment for all physician lab services—on the continued viability of the physician office lab and, specifically, the impact of these provisions on beneficiary access to laboratory services.

Increase in the Medicare Part B premium and deductible

The Administration proposes to increase the Part B premium by 2 percentage points per year so that, by calendar year 1991, the premium would be set at a rate equal to 35 percent of estimated program costs. The Administration also proposes to increase the Part B deductible automatically to the same degree as the Medicare Economic Index increase for each year, beginning in 1988. In 1987, the deductible would be increased $100.

ASIM strongly opposes this proposal. Over the last several years, Medicare beneficiaries have been forced to pay more and more out of pocket, due to the continued erosion in Medicare benefits mandated by Congress and the Administration. ASIM is particularly concerned that the proposal would adversely affect low income beneficiaries, since it provides for no protection of those individuals who cannot afford higher out of pocket costs.

Cap federal Medicaid expenditures

ASIM opposes the Administration's proposal to limit federal Medicaid expenditures to $23.6 billion dollars, a $1.3 billion reduction in federal payments below current spending projections for FY '87. In the future, payments of states would continue to match state expenditures but only up to each states individual growth limit. Federal spending increases in future years would be limited to inflation adjustments as measured by the medical component of the consumer price index.

ASIM believes that this proposal may create severe hardship for states and the medically indigent. Many states have already reduced or eliminated optional services to Medicaid patients. Further erosion of the federal contribution to state Medicaid programs carries with it the clear potential that the quality and availability of medical care to the medically indigent will be curtailed.

OTHER ALTERNATIVES FOR REDUCING THE FEDERAL DEFICIT

Although ASIM believes that health programs should not be forced to absorb additional cuts in future years, the Society is acutely aware of the need to eliminate the deficit. For this reason, ASIM strongly supports, as noted earlier, increasing the federal excise tax on tobacco and alcohol products. In addition, ASIM endorses H.R. 3950 , which would eliminate the tax deductibility of advertising for tobacco products. Both of these proposals will bring considerable revenue into the federal treasury, thus decreasing the need to make drastic cuts in federal spending on health programs, while at the same time having a positive benefit of reducing the use of tobacco and alcohol products. ASIM also supports elimination of federal subsidies for the growing of tobacco.

The Administration's budget also proposes eliminating funding for federal health planning. Unlike other items in the health budget, the health planning program does not directly contribute to patient care either through the direct provision of services or through basic biomedical research. The federal health planning program is essentially a regulatory mechanism that has failed to enhance the quality or availability of medical care provided to patients. Consistent with the Administration's and Congress' interest in reducing federal regulation, ASIM supports elimination of federal funds for health planning. The Society, however, supports planning activities on the local level.

Finally, ASIM favors a major restructuring of the Medicare program to increase revenues, to improve benefits and to improve long term solvency. In October 1984, ASIM published a paper on "Restoring the Solvency of the Medicare Program," which included some recommendations that would substantially increase revenue going into the program while improving benefits for Medicare beneficiaries. For example, the paper advocated establishing an income related cap on out-of-pocket expenses (both Part A and Part B) with hospital coinsurance varied by income; mandating a new Part A premium to help finance the income related cap on out-of-pocket expenses; and increasing Part B premiums for higher income beneficiaries only.

ASIM would be pleased to share with the Committee its complete recommendations for improving the long term solvency of the Medicare program. The Society feels strongly that this type of long term reform is far preferable to continued to reliance on arbitrary cuts in programmatic expenditures.

CONCLUSION

ASIM appreciates the opportunity to share this overview of its views on the FY 1987 budget proposals affecting health. The Society looks forward to working with Congress in modifying those elements that are objectionable, as well as in identifying alternatives to reduce the federal deficit without adversely affecting the quality and availability of medical care in this country. Moreover, ASIM would be pleased to elaborate on the rationale for its positions on the specific budget items discussed above.

G-BD-0303

STATEMENT BY

PHILIP R. WESTBROOK, M.D.

Vice-President, Association of Sleep Disorders Centers

and

Director, Sleep Disorders Center
Mayo Clinic
Rochester, Minnesota

Mr. Chairman, I am Dr. Philip R. Westbrook, a physician who directs the Sleep Disorders Center at Mayo Clinic in Rochester, Minnesota. I am pleased to represent the Association of Sleep Disorders Centers and Clinical Sleep Society which comprises over 1000 doctors and 120 facilities throughout the country that diagnose and treat patients who have difficulty falling asleep, staying asleep or remaining awake.

It is an honor to discuss proposals for Medicare coverage for fiscal year 1987. As you well-know, our population's age distribution is shifting towards the elderly. Each year, a greater proportion of our medical practices are comprised of Medicare patients. The elderly have more diseases as a group and are individually more likely to have multiple diseases. New technologies can diagnose and treat those elderly at risk for medical catastrophes before death or disability claim their tolls in quality of life and Medicare expenditures. The control of high blood pressure is just one example.

My specific message to the Committee is that many of these diseases, particularly those of the heart and lungs, change for the worse on a nightly basis during sleep. In people over 65 years of age, most disease-related deaths and disease-related medical catastrophes (such as heart attack and stroke) occur during the hours of sleep. Any new reimbursement proposals for physicians, such as prospective plans based on Diagnostic Related Groups, must recognize the 24-hour nature of disease and accordingly provide for responsible care. It is medically wrong, for example, to treat, with antihypertensive drugs and stimulants, an elderly man with hypertension who falls asleep at the wheel of his car and snores every night. Such a treatment may lead to stroke, heart attack or a multi-vehicle accident. Yet, current Medicare guidelines and payment policies force the health care system into such short-sighted treatments because patients cannot afford the necessary tests for sleep related abnormalities. A further ratcheting down of these policies in the name of cost containment would present additional likeliness of catastrophe.

Like my center at the Mayo Clinic, most sleep disorders centers are run by specialists in internal medicine who have studied for additional accreditation in diagnosing and treating sleep disorders. The emphasis on internal medicine and specialized training stems from the fact that most frequent sleep disorders are associated with life-threatening cardio-pulmonary problems during the night, such as sleep apnea, asthma, heart disease and chronic obstructive pulmonary disease. This specialization is an essential part of our ability to make proper diagnosis, and further institute a treatment regimen. For this reason we recommend that funding be continued for graduate medical education to the extent necessary to train an individual in his/her field.

Our ability to differentially diagnose patients with sleep complaints has progressed rapidly in the past ten years. We now have well-accepted guidelines and rationales for treating sleep disorders with surgery, mechanical devices, medication or some combination of these approaches. There is broad consensus as to the life-threatening nature of cardio-pulmonary abnormalities in sleep and risks of falling asleep while driving a vehicle or operating dangerous machinery. Furthermore, recent studies indicate that over 90% of the patients evaluated by sleep disorders centers are significantly improved by recommended treatments. The great impediment that we face as clinicians is that the elderly are reluctant to seek out our expertise because Medicare already pays so little for the costs associated with testing. This fact has recently been supported by reports from members of the Association of Sleep Disorders Centers. I will describe two types of life-threatening, yet treatable, medical conditions. For both, current Medicare policy effectively prevents treatment due to inadequate reimbursement.

Inappropriate use and overuse of sleeping pills is particularly common in elderly, Medicare patients. Many patients began such treatments years before modern knowledge was available. Most of the prescriptions for sleeping pills are written for this category of patients. Research indicates that cardio-pulmonary disorders, also common in the elderly, are exacerbated by sleep and account for the disproportionate number of medical catastrophes that occur during the night. Sleeping pills enhance the depression of respiration and cardiac function that normally accompanies sleep. Inappropriate use of sleeping pills in the elderly may also contribute to confusion and locomotor problems and thus potentiate accidents and falls. This vicious cycle can now be broken with rational approaches to problems of sleep in the elderly.

Second is the major problem surrounding people who cannot stay awake to function. Such patients often take prescribed stimulants, to help them stay awake while driving a vehicle or during activities that require sustained alertness. The United States Senate, in report #99-152 accompanying the fiscal year 1986 Appropriations Bill for the Department of Transportation, has recognized the potential impact these disorders have on highway safety. Stimulants, such as amphetamines, are proper treatment for only 10% of the people who have prescriptions for stimulants. For example, the most common cause of an inability to stay awake in the day is the disorder of sleep apnea which is characterized by symptoms of loud irregular snoring and high blood pressure. Stimulants are medically inappropriate for such patients. Now we know how to correctly diagnose conditions of excessive somnolence and provide appropriate treatment for the millions of Americans with these symptoms.

We ask that this Committee carefully review reimbursement practices for Medicare patients with sleep disorders as delineated in Paragraph 3132.77 of Medicare Part B coverage. The language in this section has not been changed for over ten years. Yet, the field has made many important advances. As experts in the field, we suggest that revisions be made that are in line with present knowledge and standards of practice. As a further policy recommendation, we do not believe it is advisable to increase Part B preminums or raise deductibles. Right now, access and affordability are major obstacles to many elderly persons seeking health care. To put this basic need out of reach to more elderly persons does not make good fiscal sense.

Thank you for the opportunity to present our views.

TESTIMONY

OF

COMPREHENSIVE CARE CORPORATION

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for this opportunity to submit our response and recommendations to the Administration's proposed fiscal year 1987 budget provisions for Medicare.

Comprehensive Care Corporation is a national leader in behavioral medicine services, annually treating more than 50,000 individuals for chemical dependencies and psychiatric disorders.

We understand that the Administration proposes to reduce projected Medicare expenditures by some $4.7 billion in FY 1987. While we are sympathetic to the Administration's commitment to reduce the federal deficit, we are deeply concerned about further reductions in Medicare payments to hospitals and physicians, along with increases in beneficiary premiums and deductibles.

One of the major proposals is to alter the current cost-based reimbursement system for capital expenses (which account for 7.4 percent of Medicare's payments to hospitals). The proposal would gradually incorporate Medicare payment of capital costs into PPS over the next four years through the mechanism of regulation. Beginning in FY 1987, 20 percent of a capital payment would be based on a national rate, while the remaining 80 percent would be based on a hospital specific amount. The ratio would change, until by FY 1991, it would be 100 percent national rate. Payments for return on equity to proprietary hospitals and interest earned primarily by voluntary hospitals on funded depreciation would be phased out over the next three years beginning in FY 1987. We do not believe such major issues should be decided through regulation, but instead should be a matter of Congressional hearings, debate and voting. Additionally, any new capital payments plan should treat "existing" capital in a manner "similar to current law." Hospitals should not be penalized for capital expenditure decisions made in the past.

We oppose the elimination of the return on equity as an allowable cost for inpatient hospital services. In November of 1966, Congress added return on equity capital for proprietary providers to compensate investor-owed hospitals for economic costs of acquiring needed equity capital. For-profit hospitals have raised more than $2 billion in equity capital from outside investors. But those investors require a competitive rate of return. The ROE incentive becomes even more important during this time when public funding is not readily available. Additionally, elimination of the ROE would unfairly discriminate against investor-owned hospitals. Such investor-owned hospitals must pay taxes, cannot accept philanthropy and cannot issue tax-free debt except in highly limited circumstances; they are at a cost disadvantage relative to nonprofit hospitals. Investor-owned hospitals have contributed immensely to this country in terms of new technology, greater access to care and operational efficiency. They deserve an equal opportunity to compete.

Under the Administration's proposal, hospital payments for FY 1987 would be increased by 2 percent under the Prospective Payment System. However, the hospital marketbasket is expected to increase by 5 percent. This proposal represents a further ratcheting down on payments to hospitals.

Physicians, already subjected to a 27-month long freeze on fees, will have to face actual reductions in fees, through an "adjusting" of the Medicare physican payment inflator.

Beneficiaries would experience an increase in their Medicare Part B premiums and a change in their deductible from $75 to $100 in FY 1987, with indexing after that.

To help restore monies to Medicare, we urge that Congress consider raising the excise tax on beer and wine. The simplest way to increase taxes on beer and wine would be to equalize the tax rates for all alcoholic beverages. Adjusted for alcohol content, beer is currently taxed at one-fourth the rate of distilled spirits, and wine is taxed at one-seventeenth the rate. An increase in federal excise taxes could generate additional revenues of between $4.3 billion and $20.5 billion annually. Increased alcohol taxes would be user taxes, since 10 percent of all drinkers account for 50 percent of the alcohol consumed in the U.S.

We support the Administration's proposal of catastrophic coverage for Medicare patients, as long as it does not discriminate against specific diseases, such as psychiatric disorders.

As providers of chemical dependency treatment, we note that the new alcohol/drug DRGs revised last year to reflect not only diagnosis but type of treatment received have not yet been implemented. The new DRGs, which were to be in use by October of 1985, are not expected to be operational until mid-March or after because of delay in passing the budget reconciliation bill. HCFA did not allow new alcohol/drug programs to apply for an exemption from PPS using the rationale that they would be operating under the revised DRGs which were "significantly improved" and "fully adequate." What has occurred is that the new programs have been economically shortchanged by being forced to operate under the old alcohol/drug DRGs. We urge some additional payments be provided to offset this inequity or that new programs be allowed to apply for an exemption.

During the last few years, the health care sector has endured extensive and severe cuts. Quality of care and access to care are beginning to suffer. We urge Congress to consider alternative proposals, such as the alcohol excise tax, to insure that adequate care will continue to be provided.

STATEMENT OF THE CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

We respectfully submit this testimony on behalf of several members of the Consortium for Citizens with Developmental Disabilities' (CCDD) Medicare Task Force. The Consortium for Citizens with Developmental Disabilities is a coalition comprised of consumer, provider and professional agencies which advocate on behalf of persons with developmental disabilities.

We share the Committee's dismay that so many of the President's budget proposals for fiscal year (FY) 1987 would directly impact on beneficiaries. Further, the imposition of cuts in payments to providers will also serve to increase costs to beneficiaries, and may well reduce access to needed services.

As the Chairman has pointed out, Medicare beneficiaries can ill afford to meet the sharply rising out-of-pocket costs they are increasingly being asked to bear. And the group of beneficiaries that CCDD represents, those individuals who qualify for Medicare services because they are disabled, are least likely to be able to afford increasing costs. According to the National Council for the Handicapped, beneficiaries who are disabled represent about 9% of total beneficiaries. Medicare spending on persons with disabilities comprises about 13.5% of outlays for Parts A and B. While income statistics specific to Medicare beneficiaries who are disabled are not available, the disabled population in general is much less well off than the population as a whole. The National Council on the Handicapped reports, "Of the 12.9 million persons of working age reporting the presence of a work disability, 2.6 million (or 20.1 percent) have family incomes that are below the Federal poverty threshold. This is more than double the 9.1 percent rate of the general population which has a family income below the poverty line."

Following are the Task Force's comments on the Administration's proposals and, particularly, the impact they will have on Medicare beneficiaries who are disabled.

- Increase in the Medicare Part B Premium. The Administration proposes to increase the Part B premium by two percent per year; by 1991, the premium would be set at a rate equal to 35 percent of estimated program costs. The effect of this proposal is that premium costs will more than double by the end of this decade. As we indicated earlier in our testimony, disabled individuals have a poverty rate which is more than double the national average. Disabled Medicare beneficiaries will be hard pressed to find the added resources to pay double the current premium costs. Many will undoubtedly be forced to drop their Part B coverage entirely - coverage they need for the provision of vital medical services.

- Increase in the Part B Deductible and Indexation to the Medicare Economic Index. The Administration's proposal to increase the Part B deductible to $100, and index it to the Medicare Economic Index thereafter, will also be harmful to those Medicare beneficiaries who are disabled and have few economic resources. Beneficiaries already pay extremely high deductible and copayment costs for their Part A insurance; these amounts far exceed what they would obligated to pay under most private health plans. By indexing deductible costs to the Medicare Economic Index, these costs are likely to increase much faster than will beneficiaries' income.

- Payments to Providers for Noncovered Services. Effective March 24, 1986, the "favorable presumption" of waiver of liability was eliminated for most providers through a rule promulgated by the Health Care Financing Administration (HCFA). Prior to this date, the Medicare regulations provided financial relief to beneficiaries and providers who had received or furnished noncovered services in those instances where neither the beneficiary or the provider knew or reasonably could have been expected to know that the services were not covered.

In order to qualify for this "favorable presumption," providers had to meet certain criteria, including the maintenance of a denial rate of 5 percent for skilled nursing facilities and 2.5 percent for hospitals and home health agencies. The concept of a favorable presumption of waiver of liability was also applied to comprehensive outpatient rehabilitation facilities, freestanding rehabilitation centers, hospices, rural health clinics, and organ transplant centers.

As stated in its final rule of February 21, 1986, although the "favorable presumption" regulations were discontinued on March 24, HCFA will still apply waiver of liability on a case by case basis. However, providers, practitioners and suppliers will be deemed to have knowledge that services are not covered if an intermediary, carrier, PRO or utilization review committee has given written notice that there has been a pattern of inappropriate utilization of the same, similar, or reasonably comparable services. In addition, knowledge of noncoverage will be imputed to providers when specific services have been previously denied coverage.

The CCDD Medicare Task Force believes that the termination of the "favorable presumption" provisions would impact providers and beneficiaries at a time when it is most needed. As patients continue to be discharged "sicker and quicker" under the DRG system, the need for skilled nursing, home care, and other types of post-hospital care will continue to increase. While cost-shifting is of obvious concern, it seems a misguided and even perverse remedy to penalize those providers onto whom the burden has been shifted.

Second, the rule emphasizes that major concerns to be addressed are instances in which care is being provided which is not medically reasonable and necessary or which is characterized as custodial care. Yet, despite all assumptions to the contrary, such instances are not universally agreed upon by the intermediaries themselves, nor are they generally known to the providers.

Third, little attention seems to have been paid to the fact that elimination of the presumption will result in an early curtailment of services to Medicare beneficiaries. Despite the fact that beneficiaries have been found to be in need of more services and a greater intensity of services, providers will be given the clear signal that early termination is the more appropriate course to take.

We are pleased to note that the Congress has acted to restore the waiver of liability provisions for skilled nursing facilities and home health agencies. These provisions are contained in H.R. 3128, the reconciliation legislation which was passed by the Congress on March 20,

1986. H.R. 3128 would extend the waiver of liability 12 months after the 10 regional intermediaries have begun operations for home health agencies; and 30 months after the date of enactment for skilled nursing facilities. We urge the Congress to consider a similar extension of waiver of liability for the other affected health care providers.

- Home Health Copayment. The Administration recommends a home health copayment equal to one percent of the inpatient hospital deductible, or $4.92 per visit. The copayment would apply to all visits, except those 1) following an inpatient hospital or skilled nursing facility stay, or 2) visits provided after 100 visits in a calendar year. By instituting this copayment provision, the Administration expects a savings of $100 million in fiscal year 1987.

The Task Force opposes the home health copayment. We believe that a copayment of nearly $5 per visit will act as a disincentive to the use of home health services. This result, we believe, is potentially harmful to the health of beneficiaries and fiscally unsound.

In 1980, Congress repealed limits and a deductible on home health care to increase the availability and use of these services. Home health services were and continue to be viewed as medically appropriate and cost-effective. Treating a patient at home can often eliminate the need for costly hospitalization. However, under the President's proposal, the trend toward greater utilization of home care could be reversed.

The Task Force believes that, in the interest of holding down Medicare outlays, every effort should be made to encourage the availability of services in the most cost-efficient settings. Given the limitations on beneficiary resources, a copayment on home health visits, potentially reaching $500 annually, would seriously discourage use of these services. We believe that beneficiaries would forego needed care in the home only to become more seriously ill and require extended inpatient treatment.

- Physician Reimbursement Reform. The Administration recommends physician reimbursement reforms which would substantially limit payments to physicians for many Medicare and related services. The Task Force believes that the application of extensive reimbursement limits to the services of physicians and other health care providers will have a negative impact on the availability and affordability of quality care under Medicare.

Providers cannot be expected to continue to absorb reductions in fees and payments and still provide appropriate care to eligible individuals. The Task Force believes that beneficiary access to needed health care will be curtailed as a result of these payment limitations. Additionally, we believe that the Administration's provider reimbursement proposals may encourage cost-shifting, resulting in a greater financial burden being placed on beneficiaries who are already strained by proportionally higher medical and disability related expenses.

- Modification of Payments for Non-Physician Items and Services. The Health Care Financing Administration (HCFA) implemented this proposal in its October 1, 1985 final rule. This regulation froze reimbursement to Part B suppliers at fiscal year (FY) 1985 levels for FY 1986. Future increases, beginning in FY 1987, will be limited to an inflation adjustment factor added to the previous year's "reasonable charges."

Affected Part B suppliers include: suppliers of durable medical equipment (DME), ambulance services, suppliers of prosthetic devices, portable x-ray services, suppliers of equipment used in connection with home dialysis, and independently practicing audiologists and physical therapists. While citing evidence that reasonable charge levels for DME, ambulance services, and prosthetic devices had increased significantly between 1979 and 1983, HCFA provided no evidence of such increases for independently practicing physical therapists and audiologists. The Task Force is concerned that, by penalizing these suppliers unfairly, the rule will serve as an effective deterrent to acceptance of assignment. For Medicare beneficiaries, the result will be significantly increased costs and decreased access to diagnostic and rehabilitative services.

- Voluntary Voucher Plan. The CCDD Medicare Task Force is concerned that a voluntary voucher program may not contain safeguards to ensure that all of the health plans which are available to Medicare beneficiaries provide adequate services. It has been well-documented that health care consumers often lack the skills and information to make wise health care choices. The construction of a voucher program must extend beyond Part A and physician Part B services and include all Medicare-covered benefits.

Of particular importance to Medicare beneficiaries who are disabled is the inclusion of diagnostic and rehabilitative services in any alternative plan. Such services are frequently utilized by these beneficiaries, and are a vital component in their health care.

The Medicare Task Force of the Consortium for Citizens with Developmental Disabilities thanks the Health Subcommittee and its Chairman for providing us with this opportunity to express our views.

The following members of the Consortium for Citizens with Developmental Disabilities' Medicare Task Force endorse this testimony:

American Foundation for the Blind
American Occupational Therapy Association
American Physical Therapy Association
American-Speech-Language-Hearing Association
Epilepsy Foundation of America
Mental Health Law Project
National Association of Private Residential Facilities for the Mentally Retarded
National Association of Rehabilitation Facilities
National Easter Seal Society
National Recreation and Park Association
United Cerebal Palsy Associations, Inc.

STATEMENT BY THE
FEDERATION OF AMERICAN HEALTH SYSTEMS

MICHAEL D. BROMBERG

EXECUTIVE DIRECTOR

The Federation of American Health Systems is the national association of investor-owned hospitals and health care systems representing over 1,300 hospitals with over 154,000 beds. Our member management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population. We appreciate this opportunity to present our views on Medicare proposals in the Administration's Fiscal Year 1987 budget.

The Federation of American Health Systems is willing to accept our fair share of responsibility in any attempt to reduce the Federal deficit. However, the cuts for the Medicare program proposed by the Administration once again go far beyond any sense of fairness and proportion. Consequently, health care providers will be asked to absorb much more than their fair share of the reductions.

The Administration and Congress should note that the Medicare Hospital Insurance Trust Fund does not contribute to the Federal deficit. Payments to hospitals under Medicare do not come from general revenues; they are financed by a payroll tax.

The pending bankruptcy of Medicare can no longer be held out as a legitimate reason for drastic cuts in the program. The solvency of the Medicare Trust Fund has been assured through the rest of this century primarily because hospital cost increases are dramatically lower than projected levels. As recently as 1984 it was predicted that the Part A fund would be bankrupt in 1988. Hospitals have demonstrated that with the right incentives they will vigorously cut costs. However, the right incentives under this system include an equitable rate of increase in payments from year to year, which at a minimum must be sufficient to cover the increased operating expenses caused by inflation of the hospital market basket and new technology.

During the past five years the Medicare program has been cut by nearly $40 billion. This constitutes 12% of total budget cuts even though Medicare represents only 7% of federal outlays. Now the Administration is proposing $55 billion in additional Medicare cuts over the next five years.

During the period 1981 to 1983, the nation's hospitals absorbed over 50 percent, approximately $10 billion, of all the Medicare cuts enacted by Congress. The Deficit Reduction Act of 1984 contained further substantial decreases in Medicare payments to hospitals and for FY 87 hospitals so far have had their payment rates frozen. Simultaneously hospitals came under a tough new "prospective payment" system encouraging a new cost cutting competitive spirit in the health care market place.

Hospitals have responded to these cutbacks by saving the Medicare program literally billions of taxpayer dollars through the implementation of sound management procedures designed to provide high quality care at a reasonable price. Previously hospital costs were increasing at annual rates of increase as high as 17 percent. However, this no longer is the case. Due to the more careful management of admissions, labor costs and utilization of facilities, the hospital industry has succeeded in bringing hospital costs down dramatically. In 1984, the annual rate of increase was only about 4.5%, or approximately the same as the general inflation rate.

Clearly, the Medicare hospital prospective payment plan is working. Hospitals have responded to the new incentives by cutting their expenditures. In fiscal 1984, for example, actual Medicare Part A spending was $2.2 billion or 6% less than originally projected by the trustees of the Hospital Insurance (Part A) Trust Fund.

Reductions in the growth of hospitals' full time equivalent (FTE) employees, the first reduction since World War II, shorter lengths of stay and fewer inpatient admissions resulted in sizeable savings to the Medicare program and improved operating margins for hospitals. However, such reductions in labor costs, the largest budget item for hospitals (60%), are a one time phenomenon. Once hospitals achieve efficient levels of staffing and wages, labor components will remain relatively static and cannot produce the great savings achieved during the early phases of the prospective payment system. Hospital employment prior to PPS had been growing 3 to 4% per year and wages about 8 to 10% annually. The old cost based reimbursement system which essentially paid whatever costs a hospital incurred gave no incentives for limiting FTE growth or wage increases.

However, given a direct incentive to efficiently manage their staffing, hospitals responded immediately so that employment rates in the hospital industry are now decreasing and wage increases have dropped to about 5%, a rate more in line with other industries. The result of this and other cost containment measures during the early phase of PPS produced a one time, temporary expansion in hospital operating margins.

In 1985, the annual rate of increase in hospital expenditures through October was 6.1%; (considerably lower than the 15% rate of increase reported in 1982.) Clearly, the Medicare hospital prospective payment plan is working.

Medicare Payment Policies and Hospital Margins

The Medicare Prospective Payment System has brought about a revolution in the health care system. The change from cost reimbursement came at a time when private insurers and employers also were flexing their buying power and pressuring hospitals to cut costs in order to reduce increases in health insurance premiums. These changes in the health care marketplace have had some positive, very positive, effects. However, we need to examine more closely the long term effects of some of these changes.

The Administration seems to have changed the rules of the game. We agreed to an increase in the DRG payments by market basket plus 1% when we supported passage of this legislation. Last year Congress reduced the payment to market basket plus one quarter percent. Now, for Fiscal Year 1986 we are experiencing a freeze, that is, no increase in hospital payment rates from the previous year. These spending reductions come at a time when the number of Medicare beneficiaries is exploding, not shrinking. In the next ten years the number of our elderly are expected to grow by 18 percent; the over 85 population by 51 percent. We will experience new strains on the program, even without budget cuts. The government has also drastically cut the Medicaid program, thus exacerbating the indigent care problem for hospitals. The government essentially is asking hospitals to provide the same or better quality health care services to more beneficiaries without increasing payment rates to providers of health care to cover even minimum inflation factors of hospital expenditures for labor and supplies.

The federal governments' policy for reimbursing hospitals under the Medicare program will have a "substantially depressive effect" on hospital profitability during the next two years, according to a study conducted by the consulting and research firm, ICF Incorporated (Report attached). ICF projects that operating losses for 1985 among the 5,354 hospitals covered by the study, will equal $1.7 billion. These losses increase to $3.4 billion in 1986 and $2.7 billion for 1987. It should be noted that the study assumes a highly optimistic increase of market basket plus one quarter percent for 1986 and 1987. A key finding of this study shows 59% of hospitals will fail to earn operating revenues in excess of expenses in 1986. The study further projects that actual reimbursements for inpatient hospital admissions for the hospitals in the sample would be less in 1987 than in 1984, $34.7 billion versus $34.9 billion. Several of the leading hospital management companies, representing a significant portion of the hospital industry have experienced and are projecting relatively flat earning for 1986.

Under the Gramm-Rudman-Hollings automatic cuts be implemented, hospitals will receive a reduction of 1% below the current freeze on March 1 and an additional 2% reduction in payments for FY 1987. Furthermore, the capital payment plan proposed by the Administration in its FY 1987 budget and to be implemented by regulation would reduce hospital payments by $456 million. Whatever operating margin hospitals may have enjoyed in 1984 are being quickly eroded by subsequent regulatory and congressional actions reducing Medicare payments to hospitals.

If we had frozen payments to hospitals over the last 10 years what improvements would we have sacrificed? How may lifesaving Intensive Care Units, or Cardiac Care Units or Neonatal Units would not exist today? What about technological advances like the CAT Scanner and MRI? Would we have the same quality and quantity of health care we enjoy today? Absolutely not!! Do we really want a static or deteriorating health care system?

In the long term if government continues its current payment policies, quality of care in a significant number of hospitals will be adversely affected by:

-- Lack of capital to obtain the latest technology.
-- Lack of capital to maintain and update the physicial plant.
-- Lack of capital to support research and teaching payment plan can be implemented without Congressional approval.
-- Reduced reimbursements which will not support all tertiary care functions.
-- Lack of sufficient operating surplus (profit) will mean closing units, or closing entire hospitals.

Access to care will be similarly affected as hospitals will be unable to absorb or "shift" the cost of serving indigent patients. Hospitals will avoid exceedingly complex high cost cases that particularly in small hospitals can bankrupt a facility.

Capital

The President's budget calls for savings of $456 million from its capital plan in the first year alone, FY 1987. This is a cut or at best a freeze in capital payments which can only be characterized as a freeze in medical technology or a prohibition against progress in inpatient treatment of illness. That kind of rationing should be debated carefully. There are already signs that private research and development funding is being slowed by manufacturers of medical equipment. They fear that hospitals will not be able to pay for either incurred capital costs or the increased operating costs of new services with Medicare DRG rates not keeping pace with inflation. We urge the Subcommittee to adopt the more realistic definition of budget neutrality - total expenditures which are no more or no less than would have been spent under existing law.

If the Medicare Program is unwilling to contribute its fair share toward needed capital improvements in our health system, then Congress should recognize that such improvements constitute "non-covered services" and can be charged to patients.

It is critical that any action on capital should be at the very least budget neutral.

Conclusion

Hospitals understood the prospective payment law to be a contract. We have kept our part of the contract, and the system is working. However, if Congress unilaterally changes this contract by freezing or reducing hospital payments and implementing a capital payment system that will not even begin to meet the current or future capital needs of hospitals, then hospital can hardly be expected to continue to endorse the program. Instead, you will have calls for the continuation of cost based reimbursement, with all of its perverse incentives and lose the opportunity to move forward with a program that has allowed the Medicare Trust Fund to remain solvent a decade longer than predicted just two years ago and has benefited private insurers, beneficiaries and employers as well.

Reducing hospital payments below the increase in the hospital market basket will not reward hospital managers who have cut their cost by working with their staffs, physicians and patients to adapt to the new payment system. Instead hospitals will be forced to reduce their intensity and quality of services to Medicare beneficiaries, cut their staffs and wages, postpone replacement of equipment and plant modernization, increase prices to non-Medicare patients and increase charges to Medicare patients for non-covered services.

Breaking faith with hospitals after they have responded precisely as anticipated and desired under prospective payment is a sure way to undermine our support. We urge Congress to treat hospitals fairly, and increase payment rates equitably.

SIMULATION OF THE CONTINUATION OF CURRENT MEDICARE PAYMENT POLICY

This report summarizes the results of a simulation of community hospital financial results performed by ICF Incorporated using the Hospital Investment Simulation Model. The simulation projects the likely effects on hospital financial performance if current Medicare payment policies are continued. Table 1 summarizes hospital operating data predicted by the model.

TABLE 1

AGGREGATE OPERATING RESULTS FOR ACUTE INPATIENT COMMUNITY HOSPITALS IN NON-WAIVER STATES, 1984-1988*

	1984	1985	1986	1987	1988
		(billions of dollars)			
Revenues:					
Operating**	95.0	98.3	100.4	105.3	111.7
Philanthropy & Tax Contributions	3.2	3.3	3.5	3.7	3.8
Total Revenues	98.2	101.6	103.9	108.9	115.5
Expenses:	97.3	99.9	103.8	107.9	112.0
Income:					
Operating Income	-2.3	-1.7	-3.4	-2.7	-0.3
Total Income	+0.9	+1.7	+0.1	+1.0	+3.5

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* Numbers may not add to totals due to rounding.

** Patient revenue less contractual allowances and allowances for bad debt and charity care, plus other income.

The results above are projections for the 5,354 acute inpatient hospital facilities operating in states not under a waiver of Medicare reimbursement requirements in 1984. While the model predicts continued net profitability for the industry as a whole throughout the forecast period, there are substantial hospital operating losses in the 1984-1987 period. In fact, during the 1984-1988 period, the model predicts that hospital net income will be derived from tax contributions and philanthropy, which together offset operating losses. The balance of this report analyzes the reasons underlying this predicted performance pattern. Appendix A discusses the assumptions used by the model in producing this forecast.

I. The Impact of Medicare Reimbursement Policy on Hospital Financial Results

Based on the results of our simulation, we believe that the changing pattern of Medicare reimbursement rules is the predominant factor determining hospital financial results. Table 2 summarizes the effects of Medicare reimbursement on hospital financial performance.

TABLE 2

HOSPITAL REVENUES AND EXPENSES ATTRIBUTABLE TO MEDICARE REIMBURSEMENT FOR INPATIENT ADMISSIONS*

	1984	1985	1986	1987	1988
Revenues:					
Part A Inpatient	34.9	35.4	34.0	34.7	37.7
Other Operating[1]	60.1	62.9	66.4	70.6	74.0
Tax and Philanthropy Contributions	3.2	3.3	3.5	3.7	3.8
Total	98.2	101.6	103.9	108.9	115.5
Expenses	97.3	99.9	103.8	108.0	112.0
Income	0.9	1.7	0.1	1.0	3.5

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[1] Includes Medicare reimbursements for outpatient services and non-patient income less contractual allowances and allowances for bad debt and charity care.

* Numbers may not add to totals due to rounding.

Medicare revenues for each hospital were simulated by the model based on Medicare rules in effect in each year. In all years, a cost pass-through for capital is maintained as under current law. Direct teaching payments are frozen at the 1984 level as specified by current regulations. Revenues for 1984 were estimated based on actual hospital case mix data derived from the HCFA MEDPAR file for 1984. For 1985 and 1986, DRG payments are based on the payment rate freezes in effect under Medicare regulations. For 1987 and beyond, payments are assumed to increase at the present statutory rate of increase of one-quarter percent in excess of the projected "market basket".

In attempting to reach conclusions about the effect of the Medicare Prospective Payment System (PPS), a number of published analyses draw conclusions based on a comparison of current PPS reimbursements to reimbursements that would have been obtained under the prior retrospective reimbursement scheme. We believe these analyses to be flawed by their inability to control for so-called cost-shifting in the prior law reimbursement base. Under prior law, exclusions and limitations on reimbursable costs led most analysts to conclude that Medicare reimbursements failed to cover the fully allocated costs of treating Medicare patients. To the extent that this was true, simple "old law, new law" comparisons would substantially overstate hospital profitability.

A preferred means of attacking this problem would be to allocate total inpatient hospital costs on the basis of Medicare v. non-Medicare patient days, adjusted for the extent to which Medicare case mix implies higher variable costs. Unfortunately, meaningful disaggregations of inpatient and outpatient fixed and variable costs are unavailable in existing data sets. Hence, while such an analysis could be performed on a hospital-by-hospital basis, it is not a practical approach to reaching the question of nationwide effects.

Notwithstanding these limitations, however, we believe it is clear from the results of our simulation that Medicare reimbursement policy will have a substantially depressive effect on hospital profitability during the 1986-1987 period. According to our projections, reimbursements for inpatient hospital admissions in the 5,354 hospitals for which projections were made will total $34.7 billion in 1987, a level negligibly smaller than the $34.9 billion reimbursement level projected for 1984. In a period in which total expenditures of these hospitals rises by $10.6 billion, or by 11 percent, this effective reimbursement lid must, perforce, reduce the profitability of PPS payments. In all, while the conversion to PPS in 1984 may well have increased the initial level of Medicare reimbursements for many hospitals, the effect of the payment freeze between 1985 and 1986 has substantially eroded any such increases.

To illustrate this effect, we have prepared Table 3, which compares average hospital profitability based on a number of assumptions of what initial Medicare profit margins may have been at the point of PPS conversion. The table illustrates the effect of flat average reimbursements in an era of rising costs. If reimbursement rates are held constant and costs rise 11 percent, a hospital enjoying a 10 percent profit margin in 1984 would only break even in 1987. Hospitals whose base DRG rates were less than 10 percent higher than their fully allocated costs would, by 1987, be losing money on Medicare inpatient reimbursements.

As discussed earlier, it is not possible to disaggregate base year profitability of Medicare payments using nationwide data sources. The Hospital Investment Simulation Model does, however, predict overall profitability for individual hospitals on a year-by-year basis for the 5,354 hospitals under study. Table 4 presents the distribution of hospitals by overall operating profit margins between 1984 and 1988.

TABLE 3

COMPARISON OF 1984 AND 1987 PROFIT MARGINS USING AVERAGES OF HOSPITAL DATA

Hypothetical 1984 Profit Margin	Resultant 1987 Profit Margin
20%	12%
15%	5%
10%	--
5%	-6%
0%	-11%

TABLE 4

DISTRIBUTION OF HOSPITALS BY RANGE OF OVERALL OPERATING PROFIT MARGINS, 1984-1988 UNDER CURRENT MEDICARE LAW

Number of Hospitals with Margins in Range	1984	1985	1986	1987	1988
Breakeven or Losing Money	3,166	2,793	3,161	2,924	2,575
0% to 5%	1,142	1,179	921	872	988
5% to 10%	541	640	525	566	674
10% or more	505	742	747	992	1,117

As Table 4 suggests, the Hospital Investment Simulation Model predicts that the majority of the hospitals under study will lose money on an operating basis in FY 1985-1987.

In 1984, during the conversion to PPS, 59 percent of all hospitals in non-waiver states were losing money on an operating basis. During 1985, this situation improved somewhat; the percentage of hospitals losing money or breaking even on an operating basis is predicted to fall to 52 percent. Beginning in 1986, however, that trend reverses again; the effects of the FY 1985-1986 DRG payment freeze drive 59 percent of the hospitals below profitability in 1986. In 1987, this trend begins to reverse again, as the assumed 1987 DRG payment rate increase of "market basket plus one quarter" takes effect. With a further increase assumed for 1988, the percentage of money-losing or break-even hospitals falls to 48 percent under the assumption that PPS rates continue to rise under the current law schedule.

As indicated in Table 1, sources of revenue other than operations offset these operating losses, on average, for the nation as a whole. As Table 5 shows, however, even when these revenue sources are included, a significant number of hospitals are predicted to lose money over the period under current Medicare reimbursement policy.

TABLE 5

NET INCOME AS A PERCENT OF TOTAL REVENUES FROM ALL SOURCES, 1984-1988

Number of Hospitals with Total Margin:	1984	1985	1986	1987	1988
Breakeven or Losing Money	2,455	2,139	2,576	2,380	2,008
0% to 5%	1,478	1,367	1,167	1,043	1,131
5% to 10%	815	966	713	767	890
Over 10%	606	882	898	1,164	1,325

Conclusion

Based on our simulation, we believe that the net effect of Medicare inpatient reimbursement policies in hospitals in non-waiver states will, by 1986, have a negative impact on hospital profitability. While anecdotal evidence exists that specific hospitals or specific regions were favorably affected by the transition to PPS, subsequent legislative and regulatory developments have held down PPS rates to the point that early gains may have already been offset. The model's prediction of a reversal of this trend beginning in 1987 is, of course, heavily dependent on the assumption that no further program reductions from the baseline would be enacted or adopted through regulation. Given the present budgetary environment, that assumption is undoubtedly optimistic.

Medicare reimbursement changes alone, of course, do not explain the overall drop in profitability predicted by the model. A second substantial factor is the rapid decline in hospital utilization assumptions underlying the model. We have assumed that these utilization declines, as expressed in inpatient days per 1,000 population, will level off through 1991 at 1984 utilization rates. This may or may not be a second optimistic assumption.

Third, the model's predictions about overall hospital profitability are based on the assumption, exhibited in Tables 1 and 2, of growing philanthropic contributions and government tax revenue support. Between 1984 and 1988, we assume such contributions will rise by 19 percent as a result of holding the 1984 base of contributions constant in real terms. Given the status of state and local government finances, this may or may not be a valid assumption.

Finally, the model's assumptions about non-Medicare revenues (including Medicare revenues for outpatient services) are generally based on the premise that non-Medicare margins can be maintained at historical levels throughout the balance of the decade. Given the highly competitive market for hospital services and the growing phenomenon of Preferred Provider Organizations (PPOs) and other alternative health care financing arrangements seeking substantial charge discounts in the hospital marketplace, this assumption is undoubtedly optimistic as well.

In all, we believe the projections made by the Hospital Investment Simulation Model will tend, all other things being equal, to conservatively estimate the negative impact of Medicare reimbursement policy on hospital profitability.

APPENDIX A

ASSUMPTIONS USED IN THE ICF HOSPITAL INVESTMENT SIMULATION MODEL

(Runs of 2/86)

HOSPITALS FORECAST

-- Hospitals included in these tables are only those hospitals in states without Medicare waivers in 1984.

ECONOMIC ASSUMPTIONS

-- Shown in Table A-1

UTILIZATION ASSUMPTIONS

-- The model uses actual hospital utilization rates up until 1984. After 1984, utilization rates (patient days per 1,000 population) for the under-65 population are assumed to remain constant at the 1984 level for both non-HMO and HMO enrollees. However, the growth in the number of persons enrolled in HMOs causes overall average utilization to decline over the period.

-- Utilization for the over 65 population is also held constant at 1984 rates, but length of stay can decline due to increased HMO enrollment and due to hospital response to prospective payment. Hospitals reduce expenses by cutting Medicare length of stay to a minimum of 7 days.

CAPITAL REQUIREMENTS ASSUMPTIONS

-- The model assumes that hospitals renovate or replace every 25 years, and that useful life for smaller modernization projects is ten years. Therefore, 4 percent of all hospital beds are eligible for renovation or replacement each year. (Completion of these projects, however, depends upon financial ability.)

-- It is assumed that hospitals complete some investment for modernization each year, the total amount of which depends on the number of beds ($3,000 per bed in 1981, inflated over time).

REVENUE ASSUMPTIONS

-- Payment for Medicare beneficiaries is determined using prospective payment beginning in 1984. Published HCFA rates are used in 1984 and 1985. It is assumed that rates are frozen between 1985 and 1986 and inflated by market basket plus one-quarter of a percent in each year after 1986. These runs assume no change in the indirect teaching allowance and a freeze in the direct teaching payment at 1984 levels. New wage indices are used beginning in 1986.

-- All runs assume a continuation of the Medicare pass through for capital costs.

-- Hospitals respond to the prospective payment system by reducing expenses. They do this by cutting length of stay for Medicare patients and by reducing the number of full time equivalent employees per bed. The model specifies a minimum length of stay and FTEs per bed.

INVESTMENT ASSUMPTIONS

-- The ability to complete desired investment is constrained by a hospital's financial condition. In order to obtain financing, it is assumed that a hospital must maintain a debt service coverage (DSC) ratio of 2.0. In addition, hospitals must have sufficient internal funds to make an equity contribution.

-- It is also assumed that hospitals will finance renovation/replacement and expansion projects with long-term debt if possible, even if sufficient funds are available to finance the project using its own funds. If, however, the hospital cannot meet the DSC ratio requirements, it will finance a portion of the project with internal funds. All investment projects are assumed to be completed with internal funds.

TABLE A-1

ECONOMIC ASSUMPTIONS
1981-1990

	Percent Change			
	CPI	Hospital Market Basket	Hospital Wage Rate	Long-Term Interest Rate
1981	10.20	11.70	12.30	14.17
1982	6.00	9.60	11.20	13.79
1983	3.00	6.40	7.40	12.04
1984	3.40	5.20	5.50	12.71
1985	3.90	4.90	4.90	11.86
1986	4.70	5.90	5.90	11.92
1987	5.30	7.00	7.40	12.07
1988	5.00	6.80	7.40	12.38
1989	4.60	6.60	7.20	11.95
1990	4.20	6.30	7.00	11.25

SOURCE: Medicare Trustees Report and DRI projections.

NATIONAL
ASSOCIATION
of
COUNTIES

440 First St. NW, Washington, DC 20001
202 393 6226

February 25, 1986

The Honorable Fortney H. (Pete) Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
1102 Longworth House Office Building
Washington, D. C. 20515

Dear Mr. Chairman:

The National Association of Counties appreciates being extended this opportunity to submit a written statement into the record of your March 6, 1986 Hearing on the proposed 1987 Medicare Budget.

The National Association of Counties (NACo) represents approximately 2/3rds of America's county governments. Our member commissioners are elected by their constituents to provide an array of essential services in both urban and rural areas of our nation. In addition to the traditional functions of county government to maintain roads and parks and public safety services, counties have increasingly engaged in the operation of social "safety net" activities affecting the health and welfare of their citizens. While the reasons for this expansion of county responsibility are many, chief among them are the continuing withdrawal of Federal involvement in favor of "devolution" to local governments and the increasing expectations of a public which demand governmental attention.

Historically, counties have been the health care providers of last resort for indigents and others who have been denied access to medical services. County hospitals and homes for the aged, nursing homes and community health centers have all developed as a way of assuring those who are the poorest and sickest among us that they will receive adequate care.

Unfortunately, the capacity of counties meet this persistant need has been sorely strained in recent years. Federal mandates have been imposed by successive Congresses which require broader coverage and more liberal eligibility. And, at the same time, Federal support for the financing of the various programs has eroded along with the constant threat of outright termination of valued assistance in the form of General Revenue Sharing. In short, counties are being asked to do much more, and to do it with much less.

It is not possible to have it both ways. Shifting responsibility without shifting dollars will have a serious effect on the health care of the American people. Unlike the Federal government, county governments typically do not have a range of revenue raising options. Our county governments rely on the property tax base to fund most of their activities which are not supported by intergovernmental transfers. And the property tax is often subject to constitutional limitations, as well as the practical constraints of voter resistance to levy increases.

This leads us, then, to observe that the Recommended Budget for Medicare in FY 1986 is less a part of the solution than it is a part of the problem. By limiting the increase in Medicare hospital payments to a level significantly below inflation, pressures on hospitals will increase to "dump" certain patients on county providers. The reforms proposed in payments for direct and indirect medical education will likely reduce the ability of county hospitals to provide adequate indigent care by weakening the supportive linkages between such hospitals and teaching institutions which have enhanced the staffing of public hospitals and facilitated the training of medical personnel. Increasing premiums under Part B may force some individuals to forego coverage, just as co-payments for home health services may compel patients to delay treatment in a less costly setting. Ultimately, such policies may prove a greater burden on counties in the form of patients who require more intensive treatment or higher uncompensated care expenditures.

We raise these concerns not only because they will adversely impact on county budgets, but more importantly, because the proposed budgetary changes may produce negative health consequences for the people we represent. Like the members of your Subcommittee, county officials look toward that happy day when every American in need of health care gets it. . . health care that is adequate and affordable. The proposed Medicare budget does not move us closer to that day. It takes another step in the opposite direction.

For these reasons, the National Association of Counties urges your Subcommittee to maintain the direct and indirect medical education payments and carefully evaluate the health consequences of other proposals which appear to be driven by fiscal concerns alone.

With regard to the proposal to make Medicare the secondary payor for the working aged over 69, along with their disabled spouses and dependents, it is important to recognize that this proposal, too, is another method of cost-shifting that can increase the burden on local governments in at least two ways--1) for employees who fall under this definition, local governments will have to pay increased premiums; and 2) to the extent that employers view this as a significant burden, there may be a temptation to limit the employment of the elderly--a notion which runs counter to recent initiatives to expand employment opportunities for our older citizens. Some of those denied employement may fall through the Medicare safety net and end up as indigent county liabilities.

We do not, at this juncture, presume to believe you should view these questions in isolation from the broader context of the fiscal problems confronting our nation. We have long recognized the need to reduce the deficit and understand that hard choices must be made if progress in that direction is to be achieved. But we are adamant in our position that the budget must not be balanced on the backs of the aged, the infirm, the handicapped, and the poor. The National Association of Counties cannot embrace a fiscal policy which may have that effect.

Sincerely,

Robt. B Aldemeyer

Robert B. Aldemeyer
President

STATEMENT OF
FORMER CONGRESSMAN JAMES ROOSEVELT
CHAIRMAN OF THE
NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

My name is Jame Roosevelt and I am chairman of the National Committee to Preserve Social Security and Medicare, a grassroots educational and lobbying organization with over two million active members nationwide. Mr. Chairman, thank you for this invitation to comment on the Administration's 1987 budget proposals for Medicare.

National Committee members, as well as all senior Americans, count on the Medicare program to sustain their health and well-being. I am deeply concerned that our nation's elderly will be placed in serious risk if Congress enacts the Medicare cuts proposed by the Administration's budget.

My comments today are directed at the following two general categories:

- sizeable Medicare benefit cuts that will result from increases in out-of-pocket costs to beneficiaries; and

- continued cuts in Medicare reimbursements to hospitals and doctors that threaten to sacrifice quality of care.

BENEFIT CUTS

This year's budget resurrects last year's proposed Medicare benefit cuts. Congress, at the insistence of the U.S. House of Representatives, rejected those proposed benefit cuts. I call upon the House once again to stand firm against Medicare benefit cuts so that this year's proposed cuts meet the same fate they did last year.

Proposed benefit cuts in the 1987 budget have a five-year cumulative impact on beneficiaries of $21 billion. This is 40 percent of the total $53.8 billion in Medicare savings that would be achieved over five years. How will this affect America's seniors? It will increase their out-of-pocket health care costs by about $640 on average, mostly through increases in the Part B premium and deductible. These benefit cuts will strike hardest the most vulnerable of our population - the elderly who are sick and poor. What good does it do seniors to protect their Social Security benefits from budget cuts if Medicare benefit cuts reduce their incomes just as significantly?

Please do not allow the Administration's budget rationalizations to obscure the fact that these cuts would further erode the benefit protection Congress promised America's seniors over 20 years ago when I was a colleague of yours here in Congress. Last year for the first time, the elderly spent more of their income on health care (15 percent) than they did when Medicare began. By 1990, that percentage will increase to almost 19 percent of income, even without further cuts.

The Administration is trying to shift the burden of paying for increased medical costs more and more to beneficiaries, rather than maintain the government's commitment to affordable health care. Even small cuts such as the one month delay in initial eligibility and new home health care copayment are dangerous precedents that continue to pick away at the income of seniors.

Proposed benefit cuts would come on top of unfair increases in the Medicare hospital deductible which the Administration does not propose to change. The Medicare hospital deductible has been increasing at an annual rate of 18 percent over the last three years, and it already is projected to increase 16 percent next year. These increases are the unintended consequence of the success of cost containment efforts. Medicare beneficiaries should not suffer because of this success.

At $492 for each spell of illness, the Medicare hospital deductible is more than the $480 average monthly Social Security benefit for a retired worker. And increases in the nursing home copayment, which is tied to the hospital deductible, have practically eliminated Medicare's nursing home benefit after 20 days. The daily copayment of $61.50 for the 21st to 100th day is now as much as, if not more than, the daily nursing home charge in many states. How will beneficiaries also pay for their share of doctors' fees and medicines, let alone keep up with the rent and utility bills, under these circumstances?

Even if the Administration does not recognize the problem, fortunately Chairman Stark and other Members of Congress recognize the inequity of the situation and have proposed limiting the increase. The National Committee strongly supports such legislation.

CUTS IN PAYMENTS TO HOSPITALS AND DOCTORS

The National Committee has consistently argued that across-the-board freezes are discriminatory and undermine the commitment of hospitals and doctors to the Medicare program. We support cost containment, but Medicare payments should be fair and consistent. Most importantly, cost containment should not jeopardize the quality of care Medicare beneficiaries receive. If cooperation between Medicare and hospitals and doctors breaks down, it will be Medicare beneficiaries who suffer with less access to health care and a decline in the quality of care.

First, we are concerned about the cumulative impact of the proposed cutbacks in payments to hospitals on top of last year's cutbacks. The Administration's goal appears to be to achieve maximum savings as fast as possible - maybe too fast. It is important that Medicare grant fair increases to hospitals and fine tune the payment system to correct problems that are now apparent and are well documented.

I would like to submit for the record an editorial from our membership newspaper, Saving Social Security, which states our worry that the effect of Medicare's cost containment program and cuts in payments to hospitals is to sacrifice medical care. We cannot continue our support for further cost containment until Medicare strengthens its quality care review. It is apparent to us that this will require Congressional intervention to expand Medicare's quality care mandate.

Second, the Administration has proposed needed cutbacks in payments to doctors for overpriced services, such as cataract surgery. However, the proposals do not truly reform the payment system for doctors. The Administration's budget also has no financial incentives for doctors to accept the Medicare - determined reasonable charge as full payment or to continue in the Medicare participating doctors program. Mandatory assignment would protect Medicare beneficiaries from paying doctor overcharges which, in many cases, are likely to increase.

If anything comes through loud and clear in the Administration's budget, it is the emphasis on "savings." Unquestionably, Medicare should pursue efficiencies, buying as much health care for the dollar as possible, but savings should not be the only goal of health policy. President Reagan, in his State of the Union speech, announced a study on catastrophic health insurance to be completed next year. We hope that this study takes the widest latitude in examining the financial risks that Medicare beneficiaries still face and proposes appropriate reforms. In particular, we hope that this study will recommend improved protection for long-term care needs of victims of Alzheimer's disease and of other seniors suffering from chronic illnesses, the most significant catastrophic risk that the elderly face.

In conclusion, we oppose the Administration's 1987 budget proposals for Medicare which would increase out-of-pocket health care costs for the elderly. Cuts in payments to hospitals and doctors must be carried out in a fair manner and in a way that doesn't jeopardize quality care for Medicare beneficiaries. I know that our members can count on the Subcommittee's commitment to Medicare's goal of financing quality health care for the elderly.

Thank you for your consideration.

The Official Newspaper of the National Committee to Preserve
Social Security and Medicare

Saving Social Security

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Sacrificing Medical Care

Federal pocketbook pressures to reduce the deficit may hobble Medicare's new hospital payment program. Congress established the program, called prospective payment, two years ago to curb health care costs in the nation. The common complaint—now registered loudly by physicians and patients alike—is that this new system encourages hospitals to discharge Medicare patients too quickly, when they are still ill.

There is new evidence that some hospitals may be contributing to this problem. Some may have lowered care standards and cut costs to the point where they are now raking in high profits from treating Medicare patients.

Congress and the Administration could solve some of these problems if they focused less on saving money in Medicare and more on improving the quality of care elderly hospital patients receive.

First, the quality of care squeeze has been made worse by the government's refusal to grant the prospective payment program the annual increases it needs to operate well. Second, given the latest news of hospitals profits under Medicare, the government must step in more actively and monitor the quality of care that hospitals are now delivering.

Quality of care is a critical issue for increasing numbers of old people in our society. The problems of early hospital discharge and sub-standard medical care under prospective payment must be addressed as soon as possible. We oppose a national policy which, for whatever reasons, sacrifices quality medical care for older Americans at a time when they need it the most.

The new hospital payment system deserves an opportunity to work well--through the government's efforts to fine-tune the new system now in place and to erect rigorous safeguards for quality of care. We will certainly watch this situation closely. ❦

WRITTEN TESTIMONY FROM
SIDNEY BASKIN, M.D., PRESIDENT
THE NATIONAL FORUM OF END STAGE RENAL DISEASE NETWORKS

NATIONAL ESRD DATA REGISTRY

During recent months, there has been a great deal of discussion within the renal community regarding the need to establish a dialysis and transplant patient registry. Representatives from the National Institutes of Health, Health Care Financing Administration, and Congress have joined in these discussions with interest and support. For those of us who have, over the last eight years, worked closely with our local Network Coordinating Councils and the National Forum of ESRD Networks, such discussions are not new.

Since 1981, Networks' representatives have appeared before this and other Congressional committees urging the continuation of Networks because of their critical role in the collection and validation of all national Medical Information System patient-specific data, their progress in establishing uniformity in such data nationwide through voluntary efforts, and their unique role in utilizing local data for quality assurance activities and the resolution of patient grievances. We welcome those who now join us in this effort.

We have today the same concerns and the same message as in the past. If the Administration's proposal to spend but one million dollars on ESRD Networks in FY1987 goes unchallenged, or if Congress allows the Administration to succeed at its most recent efforts to eliminate Networks by July, 1986, Congress will also be eliminating the only existing source of data on the ESRD population. In addition, Congress will eliminate the possibility for enhancing the national ESRD Medical Information System so that it can meet the needs of patients, providers, HCFA, and the Congress, for cost-containment and quality assurance.

Network data activities during recent years have been impressive. With the increase in the number of patients on dialysis and transplantation, there have been corresponding increases in the volume of work performed by Networks. Since 1981, for new patients alone, Networks have collected, validated, coded, and submitted over 125,000 patient-specific forms. During this same five-year period, Networks processed death notices on the over 70,000 ESRD patient deaths. Networks also were responsible for all Medical Information System transplant and tissue typing forms onthe over 31,000 kidney transplants performed in this country since 1981. Since 1982, Networks have carefully tracked the progress of all kidney transplant recipients, monitoring their status after discharge from the hospital, six months post-transplant, and annually thereafter. This Network activity represents the only currently existing uniform organ transplant recipient registry in the United States.

Network data activities extend beyond the processing of forms for the federal government. All of the 32 Networks have implemented local computerized ESRD patient-specific data systems. Working in cooperation with the Forum and its Data Committee, the Networks agreed in 1981 to maintain a minimum uniform data set with common definitions. Networks also agreed to maintain patient tracking systems that follow patients from the time they initiate dialysis through various modes of treatment until death. The capability to track patients by treatment modality is an important element that has never been included in HCFA's national Medical Information System program design. Also unique to Network data systems is their ability to include information on all patients served in certified facilities, regardless of their funding source, that is, data on both Medicare and non-Medicare patients. Most Networks, depending on local interests, collect, store, and analyze additional data elements.

All Networks, with ongoing advice and guidance from local Medical Review Boards, develop reports that assist in monitoring program trends and the quality of patient care. Their standard reporting includes profiles on incidence, prevalence, mortality, and patient demographics. Many Networks now have the capability to analyze the efficacy of the various treatment options with long term survival studies. Such information is essential for both patients and providers when decisions are made as to the most appropriate form of therapy. It is currently estimated that the 32 Network systems now include uniform data and information on approximately 150,000 living and expired patients. In short, fundamental components of a national dialysis and transplant registry already exist within the Network system.

Since 1984, Networks have performed these activities on an annual budget of $4.8 million, nearly $2 million less than the 1980 Network appropriation, given at a time when 52,000 were on dialysis compared to the nearly 90,000 dialysis patients we care for today. We are the only federally-financed catastrophic health insurance program in the United States today and a program with costs estimated to be over $2 billion. Data expenditures amounting to less than .2% of total program costs seem both appropriate and cost-effective. Further, these Network activities are performed without any acknowledgement by the Administration or HCFA as to their scope or importance. Rather, Networks are continually marked for elimination by the Administration based on a description of activities that do not reflect those performed by Networks. Recently, HCFA circulated a document in which it describes its rationale for the elimination of Networks. Attached is the Forum's rebuttal to HCFA's unfounded assertions. Because of the commitment of the local renal community to Network activities and objectives, these activities have continued in 1986, despite the prospect of a March budget recision and recommendation made by HCFA personnel to Network staff to concentrate on phase-out activities.

Questions have been raised as to why Networks per se are needed for the existence of a national ESRD patient registry. It has been argued that data could be collected by a private contractor. This approach was tried at the initiation of the ESRD program with a contract with Value Engineering. The effort failed. HCFA then began collecting data directly from facilities. Their efforts resulted in a less than 50% compliance rate. Frustrated by these poor results and growing criticism from both Congress and the renal community, HCFA turned to Networks and, without additional funding, required them to be responsible for the collection, validation, and submission of all aggregate facility survey data, as well as all patient-specific dialysis and transplant forms from over 1100 certified facilities.

Within the first year, Networks demonstrated their ability to collect data with a 100% compliance on the semi-annual MIS Facility Survey. This compliance rate has been duplicated during each of the past six years. It is from these Facility Surveys that HCFA's ESRD Annual Report to Congress is written and you obtain your information each year as to the number of patients on dialysis, their treatment settings, and the number of patients receiving kidney transplants.

Current HCFA recommendations to the Office of Management and Budget (OMB) regarding alternatives to the Network data system include repeating those options that were tried in the past and failed: subcontracting and HCFA collecting data directly from the facilities. There is no reason to believe these approaches are any more viable today than six years ago. An alternative plan is to collect data through Medicare fiscal intermediaries. The latest complete reimbursement data from the fiscal intermediaries is now available for 1980. Six year-old data is not useful for clinical and program management purposes. Local Networks currently provide data that are complete through December, 1985. The Forum's Annual Report, to be published in May, will provide national data current as of December, 1985.

In summary, we support Networks, simply because they are successful. Eight years of experience have provided us with the reasons why Networks are locally-based agencies that are directed and managed by the very people responsible for the submission and review of the data. Network staff are available to answer questions and train new facility staff, both being essential components for uniform data over time. Because patients and facilities participate in the preparation and use of data reports, there has been both compliance and local support for this effort over the past eight years.

The question then is why don't we have adequate national ESRD data? The problem is within HCFA's centralized processing of the data and lack of appropriate technical and professional guidance to develop sound clinical reports. Networks are addressing these problems. In December, Network Executive Directors organized a workshop to learn more on how local data could be re-formatted electronically into a uniform style for easy transfer to a centralized mainframe computer. Under the leadership of the NIH, representatives from HCFA and various professional organizations within the renal community met together at the Forum annual meeting in December to discuss how they could work cooperatively to provide national assistance and consultation. All agreed that, given the continuation of Networks and support by NIH, a national dialysis patient registry could be a reality by 1987. I seek your assistance in assuring that these two contingencies are met.

PROGRAM SURVEILLANCE AND QUALITY ASSURANCE

Since 1977, the 32 ESRD Network Coordinating Councils (NCCs) have conducted local activities, studies, audits, on-site reviews, and educational programs to enhance the quality of services available to both dialysis and transplant patients. The decentralized Network system has allowed local NCCs to identify and act on issues of concern noted through data gathered by the Network, concerns identified by consumers or providers, or findings of previous studies. Quality assurance topics have included critical issues such as hepatitis, anemia, vascular disease, diabetes, aluminum toxicity, septicemia, peritonitis, hypertension, and bone disease. Treatment outcome studies have addressed the impact of reimbursement regulations, morbidity, mortality, adequacy of dialysis, survival, rehabilitation, and hospitalization rates. Local Networks have set standards of care for staff-to-patient ratios, dialyzer reuse, water quality, nutrition standards, staffing standards, professional care, social services provided, and physical environment. Many Councils have studied and addressed the issue of treatment choice for end stage renal disease, particularly in the areas of organ procurement, long term care planning, initiation of ESRD therapy, and modality selection.

Since 1979, all Network Coordinating Councils have striven to follow the intent of Congress to encourage home dialysis and transplantation for the maximum practical number of ESRD patients who are suited for those forms of therapy. Networks throughout the country established goals and Councils monitor ESRD facilities within their areas to determine the extent to which they were encouraging the forms of therapy that are believed to be not only cost-effective for the federal taxpayer and the Medicare program but also forms of therapy that increase the independence of ESRD patients from the treatment system.

PATIENT ADVOCACY

An important objective of all Networks is to improve the quality of life of ESRD patients through the promotion of physical, social, psychological, and vocational rehabilitation. The long range goal is to restore patients to their previous level of functioning in all areas of life, wherever possible.

Networks have conducted studies on patient satisfaction, rehabilitation status, and quality of life using objective measures that include employment status, income, social and physical activity profiles, and health status indicators. Networks have surveyed patients' life satisfaction with subjective questions that enable patients to define their individual levels of personal satisfaction.

Through Network Coordinating Councils, patients and their family members have had an opportunity to work hand-in-hand with a multidisciplinary renal provider team to formulate and modify philosophy of care and policies among facilities within a Network. There is simply no other mechanism for patients that affords them such direct access to providers.

We have concerns that the Administration's proposed reduction in both facility and physician reimbursement may affect the quality of services available to ESRD patients. This may result in reduced access to facilities and/or certain treatment modalities. Patients with serious co-morbid conditions requiring intensive staff attention during dialysis could have difficulty finding chronic services. In addition, treatment schedules to accommodate employed patients my not be available. While the Forum appreciates the need to control unwarranted expenditures, it is not convinced that the Administration's proposals are either fair or well-considered.

On behalf of the National Forum of ESRD Networks, I urge the Congress to maintain the 32-Network concept through continued authorization of the program and funding at an appropriate level. Clearly, the funding recommended by the administration in its FY1987 budget of $1 million to support the activities of Networks is inadequate to accomplish the data, quality assurance, and patient advocacy purposes I have outlined. I implore you to use your influence to correct this situation and to further direct the administration to adequately support the 32 Networks in FY86 so that the strengths of this Network system that have developed over the last eight years can be maintained and enhanced.

REBUTTAL TO THE PROPOSED ELIMINATION OF ESRD NETWORKS

by the Forum of ESRD Networks

HCFA Assertion: Networks are ineffective and unwilling to assure quality and appropriateness of care.

Forum Response: ESRD Networks have been the primary force that has established locally accepted standards of care. Networks throughout the country have developed standards in many areas including, but not limited to:

- Dialyzer reuse
- Water quality for both in-center and home patients
- Staff-to-patient ratios
- Nutrition
- Staffing
- Professional care
- Social service
- Physical environment
- Patient long-term care plans

Networks have monitored facility compliance with such standards. In addition, Networks have established procedures and policies, and served as an information resource to both patients and facility staff for a broad spectrum of quality-related issues.

Networks have also analyzed data, conducted quality assurance studies, or developed protocols in a variety of areas, including:

- Patient survival
- Bacteremia
- Hepatitis
- Vascular access
- Diabetes
- Peritonitis
- Bone disease
- Patient case mix
- Hospitalization rates
- Organ procurement
- Anemia
- Aluminum toxicity
- Septicemia
- Hypertension
- Patient rehabilitation
- Impact of reimbursement rates

HCFA Assertion: Networks are inefficient as government funded programs and have experienced escalating administrative costs.

Forum Response: Networks have operated on a very small budget since their inception. Funding in CY1981 was $5.9 million. This decreased in CYs 1983 through 1985 to a constant level of about $4.8 million, without adjustments for inflation and without acknowledgement of the Networks' increased data collection and analysis responsibilities.

Networks function with the voluntary involvement of thousands of physicians, nurses, social workers, dietitians, administrators, and patients. Unpaid, they have contributed their time and expertise to improve quality of care, provide data for local and national databases, and serve as patient advocates.

HCFA Assertion: Networks have an undue focus on data collection and allow only a minimal allocation of resources for quality assurance initiatives.

Forum Response: HCFA delegated responsibility for collecting Medical Information System (MIS) forms to Networks in 1981. Networks are responsible for assuring that all required forms are submitted in a timely and accurate fashion. HCFA required that Networks ensure that facilities support data provided on the formerly semi-annual ESRD Facility Survey with the appropriate number of MIS forms. HCFA also directed Networks since 1984 to focus their efforts on data collection. If this focus was "undue," the accoutability lies with HCFA.

Networks have continued to allocate a large proportion of their staff and financial resources to quality assurance initiatives despite a lack of direction and support from HCFA.

HCFA Assertion: Networks are unnecessary in the planning process.

Forum Response: Networks provide data analysis and expertise to health systems agencies (HSAs) and state licensing and certification agencies for the very specialized services of dialysis and transplantation. HSAs and states have neither the time nor knowledge to assemble the relevant data to properly evaluate proposals to establish new, or expand existing, ESRD facilities. Networks provide HSAs and states with staffing standards, data on home dialysis and transplant rates, projected utilization rates and patient population statistics, and other information essential for thorough analysis. Networks are the only source for these data.

HCFA Assertion: Need requirements are controlled through prospective reimbursement systems and market forces.

Forum Response: This assertion is true only over the long-term, i.e., ten or more years. Unfortunately, dialysis and transplant patients suffer in the short-term situation, as providers cut social and medical services in order to sustain their operations in the face of diminishing reimbursement rates. Due to the severity of co-morbid conditions present among ESRD patients, the expectations for the current cohort's lifespans are exceeded by the time required for market forces to take effect.

HCFA Assertion: Data can be collected from the facilities and sent to HCFA central office for processing.

Forum Response: Until January 1, 1981, ESRD facilities submitted data to HCFA central office (Program Management and Medical Information System). In 1980, HCFA decided that Networks should begin in 1981 to be responsible for ensuring data submission from ESRD facilities because HCFA was unable to elicit the cooperation of its providers in providing accurate and timely data. It is inconceivable that the same facilities that provided data on a sporadic basis to HCFA before 1981 will do so now. In addition, there are now 30% more ESRD facilities in this country than in 1980.

HCFA Assertion: Health and safety regulations are enforced via State survey agencies and HCFA regional office.

Forum Response: State licensing and certification agencies rely on surveyors who are often unfamiliar with the specialized environment of dialysis and transplant units. They evaluate facility records and the physical plant on the basis of structural criteria. Unlike Networks, they do not examine the quality or appropriateness of care. They also do not set locally accepted standards of care as do Networks.

To depend on HCFA regional offices to enforce health and safety regulations is a mistake. Many regional offices have undergone high staff turnovers, resulting in personnel in positions of responsibility who are not knowledgeable about ESRD issues and care. Some HCFA regional offices have been slow and inconsistent in their responses to inquiries from ESRD providers, as well as state survey agencies.

HCFA Assertion: Dialysis facilities/services planning will be done by the States in implementing Certificate of Need (CON) requirements.

Forum Response: State CON offices have suffered from budget cutbacks. Their personnel have neither the time nor knowledge to appropriately review proposals for dialysis facilities. In addition, State CON offices have historically relied on HSAs and Networks for ESRD services planning. Currently, HSAs depend on Networks for data analysis and technical assistance in the development of their service plans. Without Networks, neither HSAs nor state CON offices will be able to objectively perform their CON responsibilities.

HCFA Assertion: Projected savings of $4.8 million are estimated between FY 1987 and 1991.

Forum Response: HCFA will not be able to save $4.8 million annually because those funds now spent efficiently and effectively by the nonprofit Networks will be "shifted to the contractor budget" [HCFA's words] and to various branches in HCFA. Without the experience of Networks and their cooperative relationships with ESRD facilities, contractors and HCFA will experience the high cost of a "learning curve" for a minimum of five years.

HCFA Assertion: There is little evidence that Networks have had a significant effect on increasing the use of home dialysis or transplantation.

Forum Response: This assertion is unfounded and implies a cause and effect that has not been proven or disproven. There is also little evidence that

Networks have not had a significant effect on increasing the use of home dialysis or transplantation. To determine the Networks' effect on home dialysis and transplantation would have required that HCFA design a case-control experiment in which the country would have been distributed randomly into areas with and without Networks. HCFA, of course, did not do this and thus, cannot validly evaluate Networks.

HCFA Assertion: Planning is another area where Networks have been ineffective.

Forum Response: In 1983, HCFA informed Networks that they were forbidden to perform prospective planning. Consequently, HCFA is responsible for the Networks' being "ineffective."

HCFA Assertion: Patient advisory and patient advocacy would be served through the State certification mechanisms.

Forum Response: State certification agencies are not in a position to serve as patient advocates. They are responsible for reviewing applications for a large variety of medical services and facilities and for conducting surveys based on structural criteria. State certification agency staff are unfamiliar with the needs of ESRD patients and do not have the relationships with dialysis units to arbitrate complaints from patients.

HCFA Assertion: Criteria to consolidate Networks would ensure that ESRD functions would continue to be performed, providing a database for meaningful analysis, an interchange of perspective conducive to effective medical review, and information on the needs of the ESRD population.

Forum Response: The 32 Networks now in existence were established along patient referral patterns and the boundaries of HSAs and Professional Standards Review Organizations. Consolidation of those areas would result in a major disruption in the now established and stable relationships between facilities and Networks. Setting up new Medical Review Boards, data systems, and other information collection systems would result in a disruption of a minimum of three years before ESRD functions returned to their current status.

HCFA Assertion: The consolidation of 32 Networks into 2 will ensure the uniformity of data collection.

Forum Response: Uniformity of data can only be achieved through a uniform data set; the Forum's Data Committee developed such a data set in 1982. Uniformity of data also requires that data be submitted by facilities in a timely and accurate fashion. Two Networks would not be able to maintain as close contact with almost 1400 ESRD providers as does the 32 Network decentralized system. Networks hold workshops and provide detailed technical assistance to facility staff in order to ensure the quality and uniformity of data. The validity of ESRD data will be seriously compromised unlesss there are 32 Networks.

TESTIMONY OF THE NATIONAL KIDNEY FOUNDATION, INC.

SUMMARY

The Medicare End-Stage Renal Disease (E.S.R.D.) Program is a model for cost containment in the health care field. When inflation is considered, per-treatment payment for dialysis is only a fraction of what it was in 1974. Further reductions in reimbursement could seriously jeopardize access to and quality of care for kidney patients. Continued funding for E.S.R.D. Networks is necessary to monitor the effect of cost containment on the E.S.R.D. population and on new patients with kidney failure.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE,

I am Ira Greifer, M.D., Professor of Pediatrics at the Albert Einstein College of Medicine and Director of Pediatrics and the Childrens Kidney Center there. For the past 20 years I have been Medical Director of the National Kidney Foundation, Inc. The National Kidney Foundation, founded in 1950, is a major voluntary health agency concerned with prevention, treatment and cure of kidney disease. The Foundation approaches these goals through programs of research, public and professional education, and patient and community services. It is in the capacity of Medical Director of the National Kidney Foundation that I am submitting this statement.

In approaching Medicare budget issues for 1987, the National Kidney Foundation understands the need for cost containment. The Foundation has played a vital role in the evolution of the Medicare End-Stage Renal Disease (E.R.S.D.) Program, the nation's first and only program of catastrophic health insurance protection. I want to emphasize the success in cost containment in the ESRD Program, which is a model in this regard. The experience of the Program is unique in the health care delivery system in this country because the increase in annual expenditures since its inception can be largely attributed to the additional number of patients served. The number of dialysis patients in this country has grown from 11,000 on July 1, 1973, when Medicare coverage became effective, to over 80,000 today. Conversely, Medicare payment per dialysis treatment has decreased in absolute dollars and is only a fraction of what it was in 1974 in constant dollars.

In 1974 Medicare established a "screen" for dialysis payments. The basic screen was $150 per dialysis session if physicians were reimbursed by the facility. Downward adjustments were made where physicians were paid directly on a monthly capitation basis and routine laboratory work was performed outside the facility. In such cases, the amount was $133 per dialysis session.

Nine years later, in August 1983, the Health Care Financing Administration implemented a new method of prospective payment for dialysis treatment. While adjusted for geographical differences in the cost of labor, average rates were calculated to be $127 per treatment for independent facilities and $131 per treatment for hospital-based units. In contrast, health care costs in the United States, as measured by the Consumer Price Index, rose 167.8% from 1974 to 1985.

There are several reasons for the remarkable cost control in the E.S.R.D. Program. First of all, there has been a dedication to science, to new methods of health care delivery and new understanding of factors which would reduce morbidity in E.S.R.D. care and the attendant costs. Secondly, there has been an incentive payment system for physician reimbursement. Due to the leadership of the National Kidney Foundation, a system of monthly payment for physicians was instituted in 1974. Physicians are paid a retainer which is not determined by the number of patient visits performed. There is an incentive to assure patient wellbeing without unnecessary physician utilization. Finally, the E.S.R.D. program has benefited from the oversight of the E.S.R.D. Networks, 32 locally-based health planning organizations with broad input from health care providers and patients.

In addition to reviewing the history of the Medicare End-Stage Renal Disease Program, the Foundation wishes to make several suggestions for its future. First of all, payments in the End-Stage Renal Disease Program have been reduced to the point that any further cuts could seriously jeopardize access to and quality of care for patients needing dialysis or transplantation. (In fact it is imperative to assess the impact of the 1983 cuts on morbidity and mortality of E.S.R.D. patients.) Moreover only current cost data should be used when reviewing reimbursement levels.

Secondly, continued funding for the E.S.R.D. Networks is necessary in order to monitor the effect of cost containment on quality of and access to care. The National Kidney Foundation Executive Committee endorsed continued support for the Networks on this basis at its June 18, 1983 meeting and the Foundation has reiterated that policy on numerous occasions in the interim. Unfortunately, funding for the Networks is slated to run out on June 30, 1986. Action must be taken now to insure funding beyond that point so that Networks will not close their doors.

I will be pleased to provide additional information on any or all of these points should the Committee desire it.

RESPECTFULLY SUBMITTED,

Ira Greifer, M.D.

TESTIMONY OF
CHARLES R. MODICA, J.D.
CHANCELLOR
OF THE
ST. GEORGE'S UNIVERSITY SCHOOL OF MEDICINE
GRENADA

Mr. Chairman, members of the Subcommittee, I would first like to express my appreciation for this opportunity to address you on the important issue of the Medicare budget proposals.

I am Charles Modica, Chancellor of St. George's University School of Medicine, Grenada. St. George's University has a special challenge in maintaining its pledge to excellence as it can never forget the 19 U.S. servicemen who gave their lives on the island of Grenada to protect the U.S. citizens who were studying medicine under a then communist regime. It is with this in mind that I am obliged to appear before you and present the facts on the cost of medical education and to assist your deliberations on reducing federal expenditures. The purpose of my testimony today is to address both the maintenance of a high quality of care and the reduction of unnecessary costs of medical education.

The cost of medical education for an undergraduate student in an American school is between $40,000-$70,000 per year per student, or a total cost over the 4 years of $160,000-$280,000. Approximately 20%-30% of this cost is paid in the form of tuition, the rest is paid by endowments, federal and state governments, draining other assets of the universities. The medical education at St. George's costs about $12,000 per year or about $48,000 for 4 years' education.

In my opinion, the reason for the existence of this tremendous discrepancy is that medical education has been unchallenged and has developed an exorbitant cost structure. St. George's has faced an organized effort by several U.S. medical societies to diminish the credibility of its students and graduates and to restrict the entry of those who have completed its educational process. This organized effort includes restricting admissions to licensing examinations, refusal to issue licensing applications, restricting admissions to residency programs, and insisting on separate examinations from those given to U.S. medical students and graduates. One of the reasons for the separate examinations is that when the St. George's students had in 1979 taken the same examination, they had scored so much higher than most of the other U.S. medical students that they were immediately barred from the successive examinations to avoid any possible comparisons. As each class finishes its second year of medical education, approximately 1/3 of that class transfers to U.S. medical schools to complete their education. Since St. George's University School of Medicine was founded in August, 1976, almost 800 students have graduated with degrees in medicine, many who return to the U.S. to practice in underserved areas.

The Journal of the American Medical Association in its January 18, 1985 issue reported St. George's University School of medicine students were the top scorers in the U.S. qualifying examinations. This rating includes approximately 1,000 medical schools in the world. The list of hospitals, many affiliated with U.S. medical schools, where most of the graduates have current residencies or have completed their specialties and subspecialties includes almost every state in the Union in 33 specialties and subspecialties. The graduates are participating in 297 different training programs in 192 hospitals. St. George's graduates are, for the most part, not doing the equal of the U.S. graduates - they are doing better. They are licensed and practice in almost every state. This is partly attributable to the fact that they are grateful for having received an opportunity and are demonstrating the initiative and persistence which led them to a medical school far distant from their families and homes.

In any reductions on federal Medicare Graduate Medical Education funding and financing, I would request that the Congress resist the overtures of organized medicine to discriminate against graduates of schools abroad, and St. George's in particular. In the event that there are any cuts proposed, I would enter a plea for equality for all U.S. medical students, whether they study in the continental U.S. or are forced to study to elsewhere.

St. George's University School of Medicine has had inspection site visits from the states of New York, New Jersey, and California. Specific approvals for educational training programs have been issued by New Jersey and California, while New York required three modifications. St. George's doubted the need for the modifications, but, nonetheless, in a spirit of cooperation, made the changes required and now anticipates approval in New York. These three states clearly demonstrate the inappropriate process used by the GAO in its reliance on those same medical educational experts responsible for the outrageous unnecessary cost of medical education to advise it on the appropriate standards to be applied to medical education.

Thank you for the opportunity to present these facts. I should be pleased to respond to any questions you may have.